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J-1

J-1

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## Legislative Assembly of Ontario

Second session, 35th Parliament

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

# Official Report of Debates (Hansard)

Tuesday 21 April 1992

# Journal des débats (Hansard)

Le mardi 21 avril 1992

**Standing committee on  
administration of justice**

**Organization**

**Comité permanent de  
l'administration de la justice**

**Organisation**



Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
Greffière : Lisa Freedman

Published by the Legislative Assembly of Ontario  
Editor of Debates: Don Cameron



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Éditeur des débats : Don Cameron



### **Table of Contents**

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Tuesday 21 April 1992

The committee met at 1531 in room 228.

### ELECTION OF CHAIR

**Clerk of the Committee (Ms Lisa Freedman):** Honourable members, it is my duty to call upon you to elect a Chair. Are there any nominations?

**Mr Robert W. Runciman (Leeds-Grenville):** I nominate you.

**Clerk of the Committee:** No, I think I'll decline that.

**Mr Robert Chiarelli (Ottawa West):** I nominate Norm Sterling.

**Clerk of the Committee:** Mr Sterling is not a member of the committee. Are there any further nominations?

**Mr Chiarelli:** I nominate Charles Harnick.

**Mr Mark Morrow (Wentworth East):** I would like to nominate Mike Cooper.

**Mr Charles Harnick (Willowdale):** I'll withdraw my name.

**Mr Chiarelli:** You don't want to suffer your first—

**Mr Harnick:** I hate to lose. It upsets me.

**Clerk of the Committee:** If there are no further nominations, Mr Cooper is elected Chair of the committee.

**Mr Harnick:** Now they can start paying him that extra \$7,000.

**The Chair (Mr Mike Cooper):** Thank you for that vote of confidence.

### ELECTION OF VICE-CHAIR

**The Chair:** Honourable members, may I have the names for the election of Vice-Chairman.

**Ms Jenny Carter (Peterborough):** I'd like to nominate Mr Mark Morrow.

**The Chair:** Mr Morrow has been nominated. Any further nominations? Further nominations twice. Further nominations three times. Mr Morrow?

**Mr Morrow:** I accept.

**The Chair:** There being no further nominations, I declare the nominations closed and Mr Morrow elected Vice-Chairman.

### BUSINESS SUBCOMMITTEE

**The Chair:** Mr Morrow moves that a subcommittee on committee business be appointed to meet from time to time at the call of the Chair or at the request of any member thereof to consider and report to the committee on the business of the committee; that substitution be permitted on the subcommittee; that the presence of all members of the subcommittee is necessary to constitute a meeting; and that the subcommittee be composed of the following members: Mr Cooper, Mr Harnick, Mr Winninger and Mr Chiarelli.

Motion agreed to.

**The Chair:** Any other business before the committee? Seeing no further business before the committee, I ask that the subcommittee meet immediately following this meeting. I now adjourn the meeting.

The committee adjourned at 1533.



## CONTENTS

Tuesday 21 April 1992

Election of Chair . . . . .	J-1
Election of Vice-Chair . . . . .	J-1
Business subcommittee . . . . .	J-1

### STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

**Chair / Président:** Cooper, Mike (Kitchener-Wilmot ND)  
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Carter, Jenny (Peterborough ND)  
Chiarelli, Robert (Ottawa West/-Ouest L)  
Curling, Alvin (Scarborough North/-Nord L)  
Harnick, Charles (Willowdale PC)  
Mahoney, Steven W. (Mississauga West/-Ouest L)  
Malkowski, Gary (York East/-Est ND)  
Runciman, Robert W. (Leeds-Grenville PC)  
Wessenger, Paul (Simcoe Centre ND)

**Clerk / Greffière:** Freedman, Lisa

**Staff / Personnel:** Swift, Susan, research officer, Legislative Research Service





J-2

J-2

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Second session, 35th Parliament

## Official Report of Debates (Hansard)

Monday 27 April 1992

### Standing committee on administration of justice

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Deuxième session, 35<sup>e</sup> législature

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Le lundi 27 avril 1992

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Monday 27 April 1992

The committee met at 1535 in room 228.

### SUBCOMMITTEE REPORT

**The Chair (Mr Mike Cooper):** I call this meeting of the standing committee on administration of justice to order. The first order of business:

"Your subcommittee met on Tuesday 21 April 1992 and agreed to the following:

"1. Assuming government amendments are tabled with the clerk on 4 May 1992, clause-by-clause consideration of Bill 74 will commence no earlier than 25 May 1992.

"2. If there is a significant number of government amendments on any given government bill, the individual ministry shall provide a reprinted bill for committee use, reflecting all government amendments.

"3. The clerk shall prepare a budget for consideration by the committee. This 1992-93 budget shall reflect a 12% drop in proposed expenditures from the 1991-92 budget."

Do we have a motion?

**Mr David Winninger (London South):** I so move the adoption of the report of the subcommittee.

**The Chair:** Any discussion?

**Mr Gary Malkowski (York East):** When you're making the budget and if the committee travels, will you include the cost of interpreters?

**The Chair:** We'll be discussing the budget right after the subcommittee report. Further discussion on the subcommittee report?

**Mr Alvin Curling (Scarborough North):** Is there any reason this said that 1992-93 shall reflect a 12% drop in proposed expenditures? Why 12%?

**The Chair:** I think when the subcommittee was looking at it we were looking at the economic times and the fact that we didn't use our total budget last time, and as a cost-saving measure we would reflect a 12% decrease in our budget.

**Mr Robert W. Runciman (Leeds-Grenville):** Same position on the provincial budget?

**The Chair:** No comment. Further discussion?

**Ms Jenny Carter (Peterborough):** We're going to discuss the budget afterwards?

**The Chair:** Yes.

**Ms Carter:** Okay.

**The Chair:** Seeing no further discussion on the subcommittee report, all those in favour? Opposed?

Motion agreed to.

### COMMITTEE BUDGET

**The Chair:** We'll now move to the budget. Everybody has it before them. Any discussion?

**Ms Carter:** I'm just wondering where the 12% has come off; what's been done?

**The Chair:** I'll let the clerk respond to that.

**Clerk of the Committee (Ms Lisa Freedman):** Actually the reduction ended up being closer to 20%. I took a look at last year's budget, in which we asked for \$384,000, and we only spent about \$284,000 of that, so there was room to reduce things. I looked at every area where we underspent, and what I did was essentially took away one week of hearings because eight weeks were never used. So this reflects seven weeks of hearings, seven weeks of members' per diems, members' meal expenses, air travel, hotel.

We also had last year about \$60,000 for simultaneous translation and interpretation into French. We had about \$60,000 budgeted, and we used about \$10,000. I think I still left about \$40,000 in the budget, which is quite a cut from \$60,000, but it's still more than what we actually used, in case we do end up translating.

So it really just came from reducing one week and the French translation.

In response to Mr Malkowski's question—and we may want to table the budget so I can go back over this—if you look at "Staff," it includes nine staff travelling on the road wherever we go. That would include room for any additional staff we had to take for interpretation. But we may want to table the budget, and I can get together with Mr Malkowski and his staff to see if it's sufficient.

**Mr Curling:** I have a question. You always start with the most difficult one: "Miscellaneous." What's that?

**Clerk of the Committee:** For example, we have no computer system currently in our office that allows us to schedule witnesses before committees. There are a number of computer systems on the market that cost about \$300 or \$400 that would allow us to keep a database of witnesses who have ever asked to appear before a committee. For example, if you came to me and said, "Who has ever appeared on a committee that was discussing housing?" I would be able to pull that up. And if people called, I could do automatic scheduling. There isn't any category; it was either "Books and Maps" or I would throw it under "Miscellaneous." Last year, I don't think I spent anything of "Miscellaneous," but it's for whatever doesn't fit.

1540

**Mr Curling:** The other one is "Witness Fees and Expenses." What is the current fee paid to witnesses who are coming here?

**Clerk of the Committee:** In the last year we also had \$10,000, and we spent about \$9,900. We didn't pay any fees. I guess there are two ways. There are witnesses' expenses for which we reimburse witnesses when the committee decides not to travel. For advocacy, the committee decided not to

travel, so we had high witness expenses. Witnesses' fees are often paid to expert witnesses, and there is, I guess, a Board of Internal Economy policy on exactly how much can be paid. This committee has never paid that. We simply reimbursed generally one person per group for hotel, either economy air fare or first-class train, and reasonable taxis between airports. It came to about \$9,900 for the last year.

**Mr Curling:** That's all the tough questions I had.

**Mr Runciman:** Mr Chair, the clerk was talking about Mr Malkowski's question in respect to interpretation. Unless I misheard, the clerk responded that in terms of travel accommodation and travel transportation, she believes there is enough flexibility within the amounts that have been budgeted to accommodate any need for interpreters to travel with the committee.

On the second page you have "Simultaneous Interpretation: \$25,000." What does that cover?

**Clerk of the Committee:** That is for the French interpreters we have on the road. If you look at the first page, it talks about nine staff. Whenever you are talking about travel accommodation, meal expenses—

**Mr Runciman:** Can you give us a breakdown on the nine staff?

**Clerk of the Committee:** It changes depending on where you're going. It's a clerk, a researcher, up to two people from broadcast and one from Hansard; that is five. The rest are the translators we have on the road when we go into designated areas. Depending on how long you're sitting and if there are night sittings—

**Mr Runciman:** You're talking about two or three language translators, plus—

**Clerk of the Committee:** For example, the select committee on Ontario in Confederation had to have four translators.

**Mr Runciman:** Let's say under normal conditions.

**Clerk of the Committee:** Normally you're talking two to three. We have to pay all of their expenses, including meal, hotel and travel expenses. Those travel expenses can either come out of "Travel Accommodation" or, when you actually flick to "Simultaneous Interpretation," really, all that's budgeted in there is what they charge us, exclusive of the hotel accommodation and everything else. I assume everywhere we're travelling is a designated area. That does not turn out to be true, which is why there is flexibility in the budget for the number of staff plus the amount that's in "Simultaneous Interpretation."

**Mr Runciman:** The people who work here in translation services are not permanent employees? Do we contract out for this rather than seconding people from within?

**Clerk of the Committee:** Up until this year we have always had to contract staff. The interpreters from within have never travelled with committees on the road. I guess an edict came down this year that, where possible, the internal translators will now have to travel on the road; so there's been a change to their job description.

**Mr Runciman:** What did they do in the past when the House wasn't sitting in committee?

**Clerk of the Committee:** I have no idea. They did not travel with committees, so that will be changing. We will still have to pay for their food, their hotel and their travel, but we won't have to pay the per diem of simultaneous translation, assuming there are enough available and depending on how many committees are travelling. So I still budgeted assuming there would not be any available.

**Mr Curling:** Following up on the same question: The clerk said that Confederation had four translators. Does it follow that justice would have four in travelling too?

**Clerk of the Committee:** Really, with the translation services that you have to contract, it depends on how many hours of the day you're sitting. Because of their contract, they work only a certain number of hours and need to rest. So if you have a committee that is starting at 8 in the morning and going until 6, plus sitting at night until 10, you need more translators than if you're sitting only for a morning or for six hours during the day.

**Mr Curling:** Take, for instance, a clerk who goes along on a trip. Would you take more if you're going to sit more?

**Clerk of the Committee:** Actually, the Confederation committee had two clerks and a student.

**Mr Curling:** Because of the hours of sitting?

**Clerk of the Committee:** It had to do with the hours of sitting, but it also had to do with the fact that the scheduling for Confederation was being done on the run, let's say, and things were being done as you were going along, so there needed to be one clerk in committee and one clerk dealing with the scheduling. Normally it's one clerk per committee, one researcher per committee. Only in special circumstances is that ever extended. It would be an exception to travel with more than one clerk or one researcher.

**Mr Curling:** I raise this because it's the best place to raise it, before someone has some misinterpretation about it. There was some talk, some concern and comment about the number of translators later on in the Confed, and I just want to make it clear that if it is necessary to take four, we've stated why it is necessary to take four. It gets rid of all the speculations and the whispering that goes on. That's why I asked if this was really necessary or was it because it was the first time and we felt we didn't know the demands that were placed on the translators and just took a complement that would not leave us short in our translation. Was that the intent: "Let's take four so we don't come up short of the work we have to do"? If that was the case, is it something we'll be reassessing or is it coming to say now, "Yes, it will be that; it will be four when we travel"?

**Clerk of the Committee:** I didn't clerk that committee but, having dealt with the translators when we did the common pause day bill, generally when you call the company and tell them what days you're sitting, they tell you how many interpreters you will need, given their arrangement with the interpreters.

**Mr Curling:** Maybe I shouldn't put this question to you but to the Chair. You are comfortable with the fact that the translators we take when we travel should be four?



**The Chair:** That was only under special circumstances that they took four; they normally just take two.

**Mr Curling:** How many are we taking this time? In our budget, how many have we made provisions for when we travel?

**The Chair:** When and if we travel, that's when we'll have to address the situation, and they will determine how many we will need, as the clerk said.

**Mr Curling:** But if we take two instead of taking four, more funds must be available in the budget. That's why I ask what provisions are made.

**The Chair:** The clerk has budgeted for three. So if we just need two part of the time and four another part of the time, it may even out.

**Mr Curling:** Okay.

**Clerk of the Committee:** I've also budgeted for three for each city and, as I pointed out before, not every city is a designated city. Getting back to Mr Malkowski's question, because we may be the committee that gets the internal translators, we wouldn't be paying any of this out to

translation. Therefore, there would be enough money to deal with the translators of Mr Malkowski's staff.

**The Chair:** Further discussion on the budget? The Chair would entertain a motion.

**Mr Mark Morrow (Wentworth East):** I'll move that we adopt the budget.

**The Chair:** Mr Morrow has moved that we adopt the budget. No discussion? And that the Chair report it to the Board of Internal Economy?

**Mr Morrow:** Yes, okay, that sounds good.

**The Chair:** Thank you, Mr Morrow.

**Mr Morrow:** That's no problem.

**The Chair:** Seeing no discussion, all those in favour? Opposed?

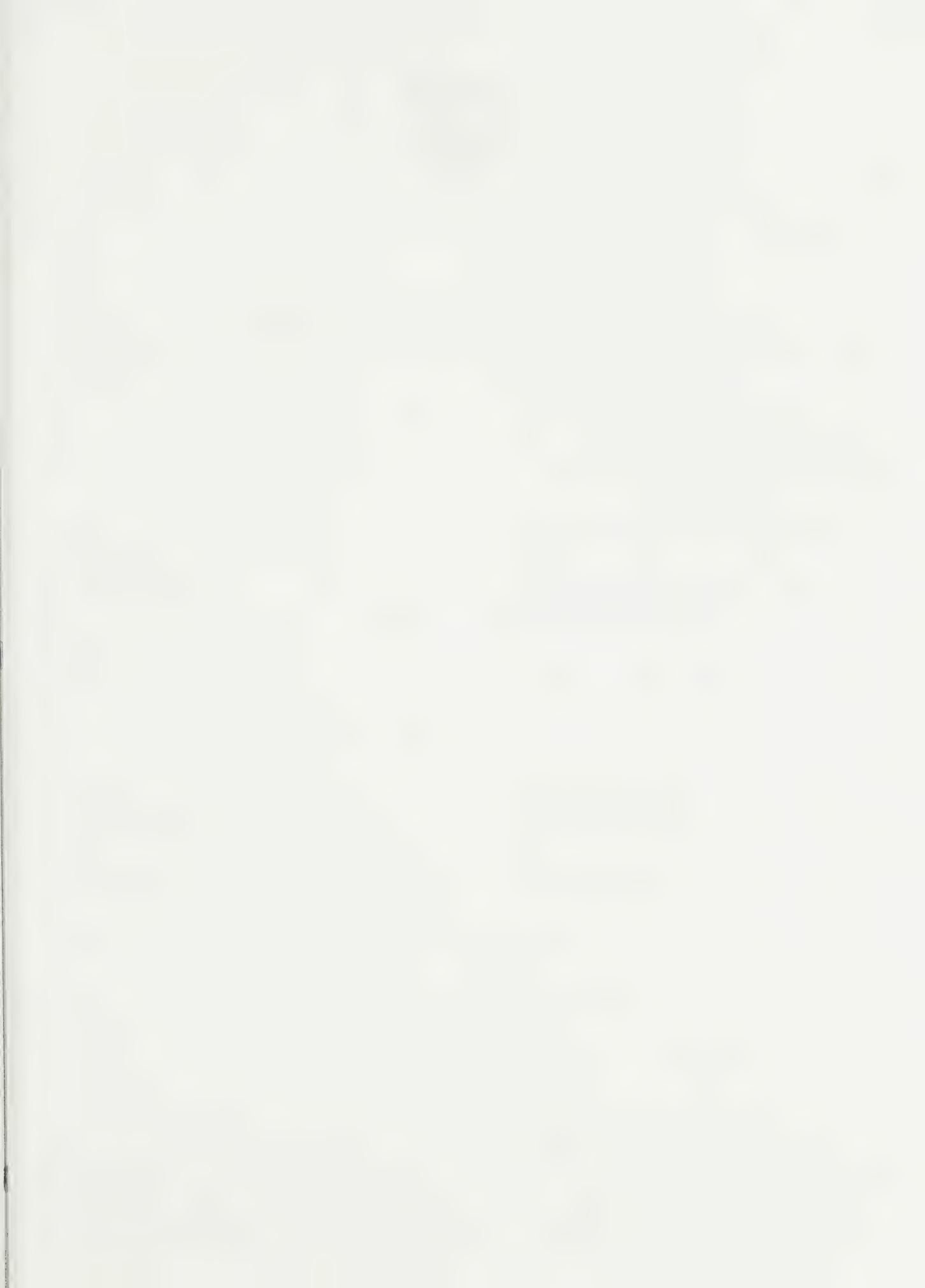
Motion agreed to.

**The Chair:** Any further business before the committee? The committee is adjourned.

The committee adjourned at 1549.







## CONTENTS

Monday 27 April 1992

Subcommittee report . . . . .	J-3
Committee budget . . . . .	J-3

### STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

**Chair / Président:** Cooper, Mike (Kitchener-Wilmot ND)

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J-3

J-3

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## Official Report of Debates (Hansard)

Monday 11 May 1992

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Deuxième session, 35<sup>e</sup> législature

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Monday 11 May 1992

The committee met at 1539 in room 151.

### ORGANIZATION

**The Chair (Mr Mike Cooper):** I'd like to call this meeting of the standing committee on administration of justice to order.

Before we begin, I'd like to welcome our visitors from the Russian Federation and Ukraine. They'll be observing the committee today. Welcome.

The reason I called this meeting was so that Mr Sterling could raise the issue he raised in the House last week. The Speaker thought it best that the committee discuss this on its own, and I thought it would be better that we discuss this before we get into clause-by-clause so that when we get into clause-by-clause we can proceed smoothly. Mr Sterling.

**Mr Norman W. Sterling (Carleton):** Thank you very much, Mr Chairman, for taking the initiative to have this meeting so that we can go through these bills in some kind of logical and rational order. As I said last week in the Legislature, I guess there is a valid point of order if, when the bills were reported back to the Legislature, there were substantial changes to that legislation in committee.

The argument could be put that the bill we passed on second reading is no longer the same bag of apples, that it's a bag of oranges we now have, and therefore the second-reading process might not have passed the bill, in a theoretical sense. I thought the more responsible thing to do as a member was to raise the issue, even though I knew it was within this committee's mandate to deal with the issue. But I thought I would raise it on the floor of the House so that perhaps the House leaders could get together in terms of resolving the issue rather than be obstreperous during the clause-by-clause hearings of the bill.

May I put forward a positive suggestion in terms of dealing with this? Perhaps the best route we might take is to have the three ministry officials come forward at our next meeting, which I guess would be the 25th. Is that correct?

**The Chair:** That's correct.

**Mr Sterling:** We could have the officials come forward and make a presentation to the committee as to what the amendments are and how they affect the legislation, and then decide after that what routes we might want to take or what kind of negotiating we might want to do in terms of timing.

I don't know whether the clerk has also sent out to all of the interest groups that have been in front of us the amendments that were put forward. I suggest that she do that before the 25th, and that we ask if they can give us some kind of preliminary indication whether they would find it necessary to appear in front of the committee again; whether the amendments meet their expectations or

whether they change the kind of presentation they might want to make to this committee.

I'm not anxious to prolong the process. I only want to be certain, because I consider it to be very important legislation, that people be given a fair chance to respond. There are 199 amendments. I haven't had an opportunity to read them myself, but I was talking to my researcher earlier this morning and she indicated that there are substantial amendments to Bill 109, and there may not be enough amendments to Bill 74 to meet the objections of various strong representations.

I just throw that out, and I would like to hear what the response of other members might be.

**Mr David Winninger (London South):** Just briefly in response, Mr Chair, I did last week approach Mr Curling, who I understand to be the Liberal whip on this committee, and indicated that the ministries would be prepared to organize a briefing for all the members on the committee in regard to the amendments. I think he was going to consult with Mr Harnick or with you about that possibility as well. Rather than delay a presentation by the ministry officials till the 25th, it might be helpful to organize a briefing in the meantime so that we don't lose that valuable time in the interval.

Second, I think there is some receptiveness to the proposal that there be some form of limited public hearings on the amendments. But with the agenda of the government being as tight as it is, either we would have to come to some agreement on this committee or the House leaders would have to come to some agreement as to how we can accommodate the public hearings with the clause-by-clause, which is scheduled to proceed on the 25th.

**The Chair:** Just a reminder that, if we were going to hold a briefing that would be on record, it would have to be tomorrow, because next week the committee will not be meeting due to constituency week. What we would have to do is have an informal briefing, if anything; otherwise we'd have to have it on the 25th.

**Mr Sterling:** That presents a problem for me in timing. Again, I'm not trying to debate it too much, but we only received these amendments last week, so you have to expect us to have a little time to rearrange our schedules in order to try to get on with the next step in dealing with this legislation.

**Mrs Barbara Sullivan (Halton Centre):** I'm interested in speaking to two or three issues that have been raised so far. Given the fact that we're dealing with three bills with something close to 200 amendments—some of which are housekeeping and related one to the other; others bear significant changes in terms of expansions and enhancements of parts of the bills—I think the issues can't be dealt with, either by the organizations who have appeared

before us in terms of their analysis and response or by members on the committee, in a hasty fashion.

The House leaders indicated at their last meeting that they have heard from some of the groups and organizations who indeed want a period of public hearing to raise some of the issues they have identified already. That, as you know, has been my view all along: that these bills are so complicated that when the amendments came in there should be that response period.

As to briefings, I'm not sure that one day of briefings before the committee is going to be an adequate time to cover the amendments that are put forward in terms of their depth and complexity. It seems to me that they ought to be on the public record when the officials from the ministries appear and that there ought to be time for the members of the committee themselves to do this study and analysis so that they can respond with questions, if that's necessary, to the officials from the three ministries who are involved.

My understanding is that the House leaders have indicated that they want additional time to consider how long a phase of public hearings would be necessary and what numbers or types of associations or groups would be most helpful to the committee in its deliberations. They have really basically left the information on the table for decision at a later time. As a consequence, it seems to me that the committee is in the position of waiting for the final decision of the House leaders and should proceed with briefings from the ministry officials on the first occasion when the committee is next to sit, which would be the 25th, and possibly include briefings on the following day as well, and, if that isn't enough, perhaps on a third day.

As I've indicated, the amendments are substantial and substantive. They are complex, as was the original legislation, and we believe that because this series of laws will affect every single person in the province they should be right the first time. That's what our aim is to achieve.

**Mr Winninger:** I would propose, in response to Ms Sullivan's submissions, that we agree to two days of briefings on the amendments to the bills on the 25th and 26th and that we defer consideration of the hearings until after constituency week, once the House leaders have met to discuss this further.

**The Chair:** Is that in the form of a motion?

**Mr Winninger:** I so move.

1550

**The Chair:** Mr Winninger moves that the 25th and the 26th be set aside for briefings from the ministry and that the decision on public hearings be deferred until after constituency week.

Is there any discussion?

**Mrs Sullivan:** My only concern would be that, were an issue to arise during those briefings that required additional time for response to members' questions, the committee would be inflexible in extending that briefing period, were that necessary.

**Mr Winninger:** I think we're showing good faith in wanting to have briefings on the amendments. I don't think we've ever been inflexible in regard to reasonable

requests for additional time, but we have to remain mindful that we had intended to start the clause-by-clause on the 25th, and that shouldn't be unduly delayed.

**Mr Sterling:** That's true. I know Mr Winninger is not inflexible, because he knows that I can be inflexible.

**The Chair:** For the record, Mr Sterling. Further discussion?

**Mr Alvin Curling (Scarborough North):** If I understand it properly, if it so happens that the five hours have been exhausted, you'll be flexible; you said you're quite flexible that it may go on for explanation of the amendments. Is this what I'm hearing?

**Mr Winninger:** I think my words speak for themselves. I think we should have our two days of briefings on the amendments, and hopefully the questions that arise will be fully answered.

**Mr Randy R. Hope (Chatham-Kent):** Also dealing with that, as we're talking about briefings to the committee, I think it's important—and I would like to form it as an amendment to the motion—that all the amendments also be forwarded to those who made submissions to this committee so you're keeping things in sync. I put it as an amendment to the motion that if we're talking about briefings for the committee, the amendments also be forwarded to all those who have made submissions before the committee.

**The Chair:** I'll refer that to the clerk.

**Mr Paul Wessinger (Simcoe Centre):** Mr Chair, I understand there's a reprinted bill that's going to be coming out, and isn't it the intention that the reprinted bills be sent to all the people who made submissions? Am I correct in that?

**The Chair:** I'll refer that to the clerk.

**Clerk of the Committee (Ms Lisa Freedman):** The committee did request a reprinted bill. I spoke to legislative counsel this afternoon and was informed that the reprint for Bill 74 now exists. Because the ministry orders the reprint, all the copies were sent to the ministry. I just spoke to the legislative assistant to make arrangements to get copies of those for the members of the committee. If the committee wishes, I can send a copy of those out to everybody who appeared before the committee.

**Mr Sterling:** Could I make one other constructive suggestion? I think this is a good route to go. If it is possible, it would probably be helpful if we were able to hold briefing sessions in the Amethyst Room where the TV is. If you could confirm that fairly early, then we could say to these groups, "All you have to do is tune in and you can get the briefing to the bill from the various ministries as well." That may or may not be possible, but if you could confirm that, you could send that kind of notice out with the copies of the bill.

**The Chair:** I'll speak to the Chair of the standing committee on social development to see if we can work out some arrangement to switch rooms. Any further discussion?

**Mrs Sullivan:** I wonder if the clerk has further information about when we can expect the consolidated bills, the reprinted Bills 108, 109 and 110.



**Clerk of the Committee:** I was told today that it should be any day; definitely by the end of the week.

**Mr Sterling:** I have a question of the clerk. Our instructions were specific from the House in starting on the clause-by-clause by the 25th.

**Clerk of the Committee:** No, those weren't House instructions. That was the subcommittee report passed by this committee.

**Mr Sterling:** I see. So that motion would then override that consideration?

**Clerk of the Committee:** Yes. I looked at the wording of the subcommittee report today, and as long as this commit-

tee is in agreement with a different date, that would be fine.

**The Chair:** Further discussion? Seeing no further discussion, all those in favour of Mr Winner's motion?

**Mr Winner:** As amended by Mr Hope.

**Mr Hope:** As long as the people get it; that's the main thing.

**The Chair:** All those opposed?

Motion agreed to.

**The Chair:** Further business? Seeing no further business before the committee, we stand adjourned.

The committee adjourned at 1555.







## CONTENTS

Monday 11 May 1992

Organization . . . . . J-7

### STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

- \***Chair / Président:** Cooper, Mike (Kitchener-Wilmot ND)
- \***Vice-Chair / Vice-Président:** Morrow, Mark (Wentworth East/-Est ND)  
Akande, Zanana L. (St Andrew-St Patrick ND)
- \*Carter, Jenny (Peterborough ND)  
Chiarelli, Robert (Ottawa West/-Ouest L)
- \*Curling, Alvin (Scarborough North/-Nord L)  
Harnick, Charles (Willowdale PC)  
Mahoney, Steven W. (Mississauga West/-Ouest L)
- \*Malkowski, Gary (York East/-Est ND)  
Runciman, Robert W. (Leeds-Grenville PC)
- \*Wessenger, Paul (Simcoe Centre ND)
- \*Winninger, David (London South/-Sud ND)

#### **Substitutions / Membres remplaçants:**

- \*Hope, Randy R. (Chatham-Kent ND) for Ms Akande
- \*Sullivan, Barbara (Halton Centre L) for Mr Mahoney
- \*In attendance / présents

#### **Also taking part / Autres participants et participantes:**

Sterling, Norman W. (Carleton PC)

**Clerk / Greffière:** Freedman, Lisa

**Staff / Personnel:** Swift, Susan, research officer, Legislative Research Service

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X514  
-577

Government  
Information



J-4

J-4

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## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Monday 25 May 1992

### Standing committee on administration of justice

Advocacy Act, 1992,  
and companion legislation

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Lundi 25 mai 1992

### Comité permanent de l'administration de la justice

Loi de 1992 sur l'intervention  
et les projets de loi  
qui l'accompagnent

Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
Greffière : Lisa Freedman

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## **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

## **Index inquiries**

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## **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

## **Renseignements sur l'index**

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Monday 25 May 1992

The committee met at 1653 in room 151.

### ADVOCACY ACT, 1992, AND COMPANION LEGISLATION LOI DE 1992 SUR L'INTERVENTION ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Projet de loi 74, Loi concernant la prestation de services d'intervenants en faveur des personnes vulnérables; Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Projet de loi 108, Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne; Bill 109, An Act respecting Consent to Treatment / Projet de loi 109, Loi concernant le consentement au traitement; and Bill 110, An Act to amend certain Statutes of Ontario consequent upon the enactment of the Consent to Treatment Act, 1992 and the Substitute Decisions Act, 1992 / Projet de loi 110, Loi modifiant certaines lois de l'Ontario par suite de l'adoption de la Loi de 1992 sur le consentement au traitement et de la Loi de 1992 sur la prise de décisions au nom d'autrui.

**The Chair (Mike Cooper):** I call this meeting of the standing committee on the administration of justice to order. As members are all aware, the briefings will start today because of the number of amendments. Briefings have been requested from each of the ministries affecting each of the bills. With the indulgence of the committee members, the briefings will take place for about half an hour and then afterwards there will be time allocated for the caucuses for questioning.

Our first briefing will be on Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons. I'd like to welcome our presenters. Could you please identify yourselves for the record and then proceed.

### OFFICE FOR DISABILITY ISSUES, MINISTRY OF CITIZENSHIP

**Ms Mary Beth Valentine:** Mary Beth Valentine, the advocacy project leader.

**Ms Trudy Spinks:** Trudy Spinks, counsel to the Ministry of Citizenship.

**Ms Linda Perlis:** Linda Perlis, policy analyst, Ministry of Citizenship.

**Mr Clément Sauvé:** Clément Sauvé, senior adviser, Office for Disability Issues.

**The Chair:** Will you please proceed now.

**Ms Spinks:** Yes, we don't have a great deal of time, so I intend to highlight seven areas of the bill where substantive amendments have been made. Of course, there are other amendments largely of a legal and technical nature.

We don't want to preclude questions being put forward on those amendments, but we will at least limit our briefing in the first instance to the major areas.

The first major area we would like to address concerns the accountability of advocates. The original bill permits the Advocacy Commission to establish minimum qualifications and educational standards for advocates and to establish procedures and standards governing their services. These qualifications and educational standards would be set out through regulations made under the act. In addition, the commission is required to ensure that advocates comply with these procedures and standards.

Concerns were expressed during the public hearings and in many of the written submissions that were put forward to this committee that these provisions do not provide sufficient assurance that advocates will be trained and accountable for their conduct or that complaints relating to advocates will be dealt with by the commission. As well, there was apparent confusion as to who would be entitled to act as an advocate under the act and how such authority would be acquired.

In response, the government is proposing to amend the act to require that every person who provides advocacy services on behalf of the commission receives the commission's authorization to do so. The relevant provision is set out in subsection 7(4) of the reprinted bill. In addition, it will be an offence to purport to act on the commission's behalf without such an authorization, and you can find that provision in the new section 34.1.

The commission will be entitled to stipulate the terms and conditions of such an authorization and will also have the authority to suspend or revoke it. The criteria and procedures relating to the granting, suspension or revocation of an authorization must be established by the commission. You will note that previously the commission had permissive regulation-making authority around matters relating to the provision of advocacy services, which would include "You may act as an advocate." It was felt that these provisions should in fact be mandatory and, accordingly, they were moved up to the function section of the bill, which is section 7.

Amendments are also proposed which will make it mandatory that the commission provide training to advocates and that the commission establish a code of conduct which advocates must follow and a written procedure for dealing with complaints relating to advocates. The complaint review procedure that is developed by the commission will be subject to the approval of the Minister of Citizenship. Again, these provisions are found in section 7 and they will apply equally to all advocates, whether they are employed on a paid or a voluntary basis.

The term "advocate" has been expressly defined to mean a person who is authorized to provide advocacy

services on behalf of the commission. The definition is only applicable to the term as it is used in the Advocacy Act. It is not intended to preclude other persons or groups from calling themselves advocates or providing advocacy services, provided that they do not purport to do so on behalf of the commission. A clause has been added which we hope will make this intention clear, and that is found in subsection 34.1(3).

Another area around which there seemed to be some confusion concerned the role of the advocate. The original bill addresses the types of advocacy services that advocates may provide. These include the provision of services to individual vulnerable persons to help them express their wishes and exercise their rights. Advocates will also provide services as required under the companion legislation, the Consent to Treatment Act and the Substitute Decisions Act. The latter function is primarily limited to informing persons of the meaning of a finding of incapacity and the right to challenge that finding.

1700

As I indicated, these provisions appear to have been widely misinterpreted as giving advocates the authority to override decisions about medical treatment and other matters. This was never the intention when the bill was drafted. To make this clear, a clause has been added which explicitly states that advocates are not conferred any authority under this act to make decisions in place of or on behalf of the vulnerable person. The relevant section is section 15.3. For further clarity, the term "rights advice" has been added to refer to the advocate's function under the other acts. That reference is found in clause 7(1)(d). In addition, an amendment is proposed which prohibits an advocate from doing anything that is inconsistent with the instructions of the person for whom he is acting. That statement is found in section 15.1.

Another area we felt was not sufficiently clear concerns the advocate's relationship with family members and substitute decision-makers. Considerable concern has been expressed that the act does not facilitate cooperative relationships among advocates and the family members and friends of vulnerable persons. In response, amendments are proposed that will require advocates wherever feasible to consult with the vulnerable person to determine whether there are family and friends who could provide support. If the vulnerable person wants this assistance or if he or she is incapable of instructing the advocate, the advocate must, if the circumstances permit, assist the family or friends in their efforts. This requirement is set out in section 15.2.

Complementary amendments are also proposed to these provisions and they govern access to information and confidentiality, sections 24 and 30 respectively. These amendments would enable advocates to obtain the information necessary to contact the family members and friends of vulnerable persons who are incapable of instructing an advocate and to bring concerns regarding the care of such persons to the attention of family members, friends and so forth.

Another amendment requires that a committee comprised of a majority of family members, care givers and health and social service practitioners be established to

provide advice to the commission. This is an amendment to section 10. In addition, the commission's mandate to provide public information programs would be clarified to ensure that persons with a special interest in vulnerable individuals, including family members, could participate in these programs. That change is set out in subsection 7(5).

The bill has also been criticized for failing to spell out the way in which legally authorized substitute decision-makers and advocates will interact. As a result, when a vulnerable person is incapable of instructing an advocate it is proposed that the act be amended to expressly authorize advocates to provide advocacy services on the basis of instructions given by the vulnerable person's substitute decision-maker. The substitute decision-maker would include, for example, a guardian of personal care or a person operating under a power of attorney for personal care. That reference is found in section 15.3.

A related amendment would authorize advocates to access the vulnerable person's records with the consent of the substitute and would authorize advocates to disclose the information they obtain about the vulnerable person from the records to the substitute.

Some questions have also been raised concerning the provisions governing access to records. Under the original bill, advocates are only entitled to have access to records relating to vulnerable persons that are held by facilities, and these are largely publicly regulated institutions and referred to in the schedule appended to the act. Other records are not accessible, such as those held by unregulated boarding and rest homes, which would include, for example, a place such as Cedar Glen. The demonstrated problems associated with these homes suggest vulnerable residents of these premises should be accorded the same protection as those living in facilities.

As a result, the government is proposing that provisions governing access to records be amended to include the records maintained by the operators of such premises. The reference to these records would be found in subsection 24(1).

It has also been noted that access to records is currently restricted to records maintained by residential facilities only. The effective resolution of a vulnerable person's problem may necessitate access to records which are maintained in respect of a vulnerable person in a non-residential program, such as a community mental health program or a vocational rehabilitation program.

In response, an amendment is proposed which would permit access to records held by certain programs which are administered by the Ministry of Health or the Ministry of Community and Social Services. These programs would be identified through consultation with these ministries and designated under the regulations. The relevant statutory references are subsection 24(1), clause 25(1)(c) and clause 36(1)(e.1).

There are also some amendments proposed to the section which governs access to records and disclosure of information which is obtained for the purpose of systemic advocacy. The original bill entitles an advocate, with the commission's consent, to access certain records relating to



vulnerable persons for the purpose of systemic advocacy. Information obtained for this purpose may be disclosed to other advocates, members of the commission, persons who work for the commission or in community programs and vulnerable persons. Concerns were expressed that the purpose of this access is too broadly defined and that the disclosure provisions do not adequately protect the privacy of vulnerable persons.

In response, amendments are proposed to section 25 which would narrow the purpose of the access to "detecting and demonstrating systemic policies or practices that may be detrimental to vulnerable persons." The disclosure provisions in section 33, which deal with information obtained for the purpose of systemic advocacy, have been tightened. These new provisions would prevent the disclosure of personal information without the consent of the person to whom the information relates unless that information is already publicly available.

Another very significant area of change concerns the provision of non-instructed advocacy. The original bill authorizes the commission to make regulations relating to the provision of advocacy services to vulnerable persons who are mentally incapable. Many groups have expressed concern that these provisions do not outline with sufficient clarity the commission's mandate to provide advocacy services to such persons. They also point out that several of the act's provisions, particularly those governing access to information and disclosure of information, would override the regulations and prevent effective advocacy for those who most need it.

The government is therefore proposing several amendments to the bill. The purpose and functions sections of the bill, that is, section 1 and section 7, would be amended to state that "the commission may provide non-instructed advocacy services for those who are incapable of instructing an advocate where the health or safety of such persons is at risk of serious harm." Advocates would be authorized to see the records relating to such persons and disclose information to appropriate persons. Disclosure by the advocate to the public guardian and trustee would be mandatory in these cases. In addition, advocates will be entitled to obtain the information necessary to contact the friends, family members and substitute decision-makers of incapable persons and will be authorized to disclose information concerning their care to these individuals.

The last major area we wish to address today concerns the powers of entry. The original bill provides that advocates may enter private premises without a warrant and at specified times for the purpose of providing advocacy services to vulnerable persons. The advocate must have reasonable grounds to believe that the vulnerable person wants or could benefit from the services of an advocate. Unlike entry to facilities, it is not an offence to deny an advocate entry to private premises. Entry may be enforced through a warrant. An advocate must leave the premises promptly if the vulnerable person declines the services.

1710

The purpose of this entry power is to ensure that vulnerable persons are not denied the services of an advocate in situations where another person or persons control who

visits them or prevent them from learning about the availability of the services. It is particularly intended to benefit those who may be at risk of abuse, neglect or exploitation.

Concerns have been expressed that this power unreasonably interferes with privacy rights. In response to these concerns, it is proposed that the right of warrantless entry be limited and narrowed to three situations: where the advocate has reasonable grounds to believe the vulnerable persons wants the services of an advocate, where there is a risk of serious harm to the health or safety of the vulnerable person, or where the location of the premises makes it impractical to obtain a warrant. Accordingly, obtaining a warrant would tend to be the rule rather than the exception as it relates to private premises. The relevant provision is set out in section 18.

You'll note that the entire section governing powers of entry has in large part been redrafted. The bulk of the other changes is simply to improve the drafting to clarify matters and address some legal issues.

Those are all the major areas that we wish to cover in this briefing, although as I indicated earlier, we'd welcome questions on these or any other areas of the bill.

**The Chair:** Thank you. Questions or comments?

**Mrs Barbara Sullivan (Halton Centre):** I want first to acknowledge the work that has been done by the government in reflecting through amendments that have been put forward so far many of the comments from the groups and agencies who appeared before the committee. As you will understand, we are still working our way through the amendments and feel they have gone a long way to meeting some of the needs that have been put forward. We have already identified areas, however, where we will indeed be putting forward further amendments.

In reality, having given the kudos for that, I also have to underline that I think it's really a shame that in this combination of bills, 200 amendments were necessary as a result of what really was inadequate pre-work in relationship to the ways the bills work together and the kinds of issues which are very sensitive to the groups and organizations ultimately affected by those bills.

There are a couple of areas I wanted to clarify with you, one of them relating to obtaining the warrants to enter premises. Would you clarify why you would have included the location of premises being impractical?

**Ms Spinks:** We consulted quite extensively with constitutional experts and so forth in order to bring these provisions, as best one can in anticipation, into line with the charter. We were advised by them that when one is addressing issues relating to warrants, it's common and makes a great deal of sense to include such a provision because you may be dealing with places that are in very remote areas of the province where access to a justice of the peace may be almost impossible in terms of the time frame and the distance.

**Mrs Sullivan:** On a larger question, I wanted to review an issue that I've spoken with the Ontario Advocacy Coalition about, one that certainly the coalition is very strong in its support of, and that is that the community agencies would be those which do not provide services



other than advocacy services to vulnerable people. I believe it is subsection 7(2), but I may have the wrong section.

**Ms Spinks:** It is; you're right.

**Mrs Sullivan:** I wonder if the government has explored the possibility that in those very remote areas, or areas where community services are offered in a combined way, indeed the provision of advocacy services through community agencies may well be hindered if the agency offering advocacy services is limited to doing only that. I think, by example, of some agencies which would be doing case work but which might also provide the assistance vulnerable people would require, whether it's rights advocacy or other approaches in relation to influencing change in government or other services. I would like to have some discussion of the policy decision in that area because I think we may be leaving some people out or leaving them without access to services that would otherwise be available.

**Ms Spinks:** I think I might refer that question to Ms Valentine.

**Ms Valentine:** You're certainly correct, Mrs Sullivan, that the advocacy coalition is very concerned about this particular issue. It relates primarily to the issue of independence, the importance of the commission being independent from government and advocacy services being independent from service providers, both financially and administratively. The issue relates the same way at a community-based level, within a community agency that is providing direct services.

Certainly the concern you've expressed about wanting to assure that advocacy is available to people has been discussed in some detail. We are well aware of situations where there may not already be services available in a community. I think one of the approaches would be to support and encourage an actual group, committee or board to form that would be able to provide its own services. That's very much in line with the concept of participation of vulnerable people, empowerment of vulnerable people etc. On the other hand, there are certainly ways for a ministry to be able to flow funds through another body for a temporary period if necessary in order to ensure that funds can flow into a community.

There are a number of ways for that to happen. For instance, when community mental health services began flowing funds, late in the 1970s, for a number of years many small agencies were attempting to establish community supports for ex-psychiatric patients. Frequently funds were flowed through an agency such as the United Way or a church group, a number of different sources, in order to allow the particular group providing the services to get in place.

If I could use, for instance, the example that if a community agency is providing both advocacy and support services—perhaps you'll find that my examples tend to swing along the psychiatric services line, because that is my background in mental health. During the course of clause-by-clause etc I will also probably use examples related to the patient advocate program, because until

being seconded to this position I had been the coordinator of the patient advocate office for a number of years.

My example, then, would be that at a community-based agency you could have services such as residential accommodations, case management, any number of programs—day activity programs etc—operating out of an agency. Where a client, a disabled person, has concerns about the types of services being offered by that agency, I think the inherent conflict of establishing advocacy within such an agency is obvious from that standpoint. It makes it somewhat difficult to have an advocate sitting in the next office to the person running the group home program or the case management program.

**Mrs Sullivan:** You have used two examples which underline the exact kind of concern I have. By example, the church groups and the United Way would be excluded by the clause, as it's written, from flowing funds through to an advocacy community agency which would be established at some point.

1720

**Mr David Winninger (London South):** On a point of order, Mr Chair: I just would like to question the propriety of having people of the bureaucracy, knowledgeable as they are, being asked to respond to policy-oriented questions. I would submit that they're here today to answer questions of information regarding the amendments to the act. I think we're diverting the discussion into policy and I don't think it's appropriate that people in the bureaucracy be dealing with policy questions today.

**The Chair:** Thank you, Mr Winninger. Any policy questions should obviously be directed to the parliamentary assistants. They may respond if they choose.

**Mrs Sullivan:** Do they choose?

**Mr Gary Malkowski (York East):** You're talking about issues. Which issue do you want me to respond to? Could you rephrase your question, please?

**Mrs Sullivan:** We've just been discussing the policy decision which is being made in the legislation: that the only agencies which will receive funding, which will be providing advocacy services to vulnerable persons, will be those agencies which provide only advocacy services. My view is and my concern is that there will be some areas of the province which will be underrepresented, some agencies which will not be able to access that funding because indeed other services are provided, including, by example, fund-raising services for support in the community.

I understand the issue of conflict in relationship to the particular organization. I'm wondering if the issue has been further explored to ensure that if there is an organization, the United Way or church organizations which do provide other services, or perhaps an organization such as the Association for Community Living—if those associations are not allowed to provide services, why not?

**Mr Paul Wessinger (Simcoe Centre):** Mr Chair, just for the purpose of clarification, I would like to know where in the act it says that a community agency has to provide only advocacy services in order to be an advocate, because reading the definition of "community agency," it

just states that it means a non-profit community agency that is authorized.

**Mrs Sullivan:** Subsection 7(2).

**Mr Wessinger:** The only restriction, it appears, is that they do not provide services to vulnerable persons. It would seem like you could provide other services, other than to vulnerable persons. I'm just reading and in that definition it seems it's only a situation where you don't want an advocacy service provided by a group where there might be a conflict of interest. I can understand that aspect of it from a policy point of view, and that would be a policy decision with respect to subsection (2), but I would think that would be the only restriction, based on that. Maybe I'm misunderstanding the question.

**Mrs Sullivan:** I think counsel understands. Perhaps when we do clause-by-clause we could look at either a reframing or an approach where the issue could be discussed at some greater length. I think there will be people who will not be able to access services. If they are vulnerable and unique and there is no local agency, by example—even all vulnerable people within a community—this will be problematic. They could not be helped by an existing agency which would provide other services.

**Ms Spinks:** If I could just provide a point of clarification, certainly the intention of subsection 7(2), as it is drafted, is to provide that the commission may only authorize community agencies that are not in the business of engaging services that are not strictly advocacy services.

**The Chair:** Further, Ms Sullivan?

**Mrs Sullivan:** No, thank you. Since we're restricted in terms of the information we can receive on policy matters, we would rather wait to hear further from groups and agencies that have examined the bills more thoroughly, when they are finished that process, and deal with some of these issues at that time.

**Mr Norman W. Sterling (Carleton):** I'd like to thank you for obtaining these facilities today so the groups that were so interested in the bill will be able to look at the tapes of the proceedings here today and get the benefit of your briefing as well.

At first blush, I think you've tried to meet some of the issues that were of concern to myself and my party, and I congratulate you on that. I have not had an opportunity to look at the bill in great detail. We're dealing with legal language and we're dealing with a number of groups that had significant concerns about your bill, at first blush. I'm anxious to hear from the Ontario Friends of Schizophrenics and I'm anxious to hear from the Alzheimer's group as well, to see what their reactions are after they have an opportunity to look at it.

Unlike my Liberal colleague, though, I do not find the number of amendments shocking. I find it refreshing that the government is willing to look at the bill and amend it significantly, because quite frankly, with due regard to the fact that the advocacy bill is the first try of its kind in basically any jurisdiction, I don't think we as legislators can expect the first try to be the be-all and end-all. Therefore, I think we've got to feel our way through this process. That's been part of my concern in terms of making

certain everybody has an opportunity to deal with this, not dragging their feet, but giving them due opportunity to consider the amendments and have an opportunity to come and talk to us again if they deem that necessary.

I have some specific questions I'd like to go through. At page 3 of your brief, section 15.1, you talk about, "For further clarity, the term 'rights advice' has been added to refer to the advocates' function under the other acts. In addition, an amendment is proposed which prohibits an advocate from doing anything that is inconsistent with the instructions of the person for whom they are acting."

We have other legislation we're going to consider in conjunction with this, and I don't think we can separate them totally. What happens if a person makes a power of attorney for personal care and he appoints a friend to make the decisions on his behalf and that friend or attorney, as he would be called under the legal document, indicates he wants such-and-such a treatment? Does that exclude the advocate totally if that person says: "I'm appointed by the incompetent person. I believe that person wanted this kind of treatment"? Is there any function for the advocate under those circumstances?

1730

**Ms Spinks:** There isn't a function for the advocate except in limited instances—and you'll hear from Mr Fram more on this—where an advocate may be providing rights advice during the process of validation, which, it is proposed, may be somewhat changed. I'll let him give you the details on that, but with respect to the rights advice function as it may come into that process, that is not a situation where an advocate is commenting on the nature of the treatment that's proposed or the provisions of the power of attorney. It's simply a rights advice function, and I wouldn't call that instructed advocacy.

The purpose of section 15.1 is to ensure that when you get into a situation where an advocate has been retained by an individual to act on his or her instructions, the advocate acts consistently with those instructions.

I guess the short answer to your question is that at no time is it contemplated that the advocate would be attempting to tell the vulnerable person, or the individual who is the grantor of the power of attorney, or the attorney, whether or not the particular treatment is in the best interests of the individual or not. That is really not the advocate's function. So in that case they're not into a situation of instructed advocacy.

If, on the other hand, the grantor of the power of attorney was capable of giving instruction and instructed the advocate to take certain steps, perhaps communicate with the person who has a power of attorney and so forth, or with the doctors, he or she would be permitted to do that, providing he, again, acted consistently with his client's instructions. Does that clarify it?

**Mr Sterling:** What happens in the case we heard in terms of Alzheimer's patients where there are lucid periods and there are periods where people are not lucid? Often people can understand that they are at the beginning stages of Alzheimer's disease, and in their lucid period they give a power of attorney. But lots of unfortunate things happen



after a person suffers from this disease. Often they claim silly things—people are stealing their money—and this can be their family that is involved. Where does the advocate become involved then?

**Ms Spinks:** The individual who has been given the power of attorney, assuming that all the requirements under the Substitute Decisions Act have been met in terms of the capacity to grant it, has a valid power of attorney and it is not up to the advocate to unilaterally interfere with that. I think what you are asking me is whether or not the advocate would perhaps advise people on what rights they had in terms of revoking the power of attorney, if that's the expression they gave, in a period of time when they were not lucid. If that is the case, I think we have to remember that advocates will, we trust, be trained to deal with situations where individuals vary in their lucidity, and again I think we need to come back to the first principle that the rule is that the advocate acts on the instructions of the individual. If, in the advocate's opinion, that person is not capable, then he or she is only permitted under the act to act in certain limited instances.

**Mr Sterling:** Can I ask you another question? In terms of accountability of advocates, you propose an amendment in section 7 that requires you to get the authorization of the commission to act on their behalf. For instance, we had a brief from adult protection workers, and they said to this committee that they spend somewhere between 30% and 40% of their time as an advocate. Are they going to be controlled by the commission in their advocacy function, or are they going to be outside of the act?

**Ms Valentine:** There's no intention that the adult protective service workers would automatically be required to come under the commission. It's anticipated that many people such as family members, APSWs, case managers etc will still fulfil a certain advocacy role, a certain level of advocacy, but there likely will be times—and we would hope a good liaison is established between members of the Advocacy Commission and such other groups—that a referral might be made from a case worker, an APSW, etc to the commission if that person was not able to resolve within the context of his or her own abilities and limitations.

**Mr Sterling:** If a family or somebody who purports to represent a vulnerable person is dissatisfied with what an advocate has done, who is going to review the conduct of the advocate?

**Ms Spinks:** We have proposed a provision that will require the commission to establish a written complaint review procedure, and that will have to be vetted by and approved by the Minister of Citizenship. It is anticipated that this procedure would set up the rules relating to the commission's method of dealing with the complaint. I don't think there is anything in the act that would preclude the commission, if it so chose, from perhaps suggesting that another individual, someone outside the commission, review complaints as well. That's not precluded by the legislation, but it would be the commission, subject to the approval of the minister, that would decide what that pro-

cedure will be. It hasn't been spelled out in detail in the legislation, but again it's quite common with respect to regulated occupations that there is a mandatory requirement that a complaint procedure be developed.

**Mr Sterling:** What is the discipline that is meted out if someone has stepped outside the boundaries?

**Ms Spinks:** That would depend on the rules the commission developed pursuant to its regulation-making authority, which relates to the authorization section, so I don't think one could say with any certainty exactly what would follow in what situation. That applies as well to the law society or the College of Physicians and Surgeons of Ontario and so forth. Every case has to be evaluated on its own facts. The commission does have authority, however, to suspend or revoke the authorization or to attach terms and conditions to it.

Also, I think we need to remember that the advocates will be employees either of the commission or of a community agency, so they do have an employer relationship and accountability.

**Mr Sterling:** I guess there is an accountability, but there's also a problem with that as well. When you're dealing with professional organizations in general, there's not the employee-employer relationship and therefore they can discipline a member of their profession, and do, and say, "You no longer can practice, period."

**Ms Spinks:** There is authority under this act for the commission to revoke an authorization, which has the same effect.

**Mr Sterling:** What happens to them, then, in terms of the employee-employer relationship?

**Ms Spinks:** The employer would have to decide, I suppose, how to proceed in light of that revocation. The two don't necessarily go hand in hand unless it's a term of the individual's employment that he or she has an authorization and is in good standing, so to speak.

**Mr Sterling:** Can I ask one other question? You have no doubt studied Bill 109, have you?

**Ms Spinks:** Somewhat. I wouldn't speak for the Ministry of Health.

**Mr Sterling:** The concern of our health care professionals was that the triggering mechanism for advocates was almost universal. In other words, as I understand it, on every procedure in a vulnerable—that has changed, has it?

**Ms Spinks:** The government is proposing changes to the sections that deal with rights advice, the circumstances in which rights advice would have to be provided and what type. I wouldn't assume to speak for the Ministry of Health and I think perhaps we should wait for tomorrow to have them explain to you exactly what changes those will be, but the rights advice functions are somewhat circumscribed in Bill 109.

1740

**Mr Sterling:** What is your view of what is going to be the normal triggering mechanism for an advocate to be engaged?



**Ms Spinks:** Again, I don't want to speak for the Ministry of Health—its representatives will be here—but under Bill 109 it has been narrowed to certain circumstances including where individuals object to the proposed treatment, ask to see an advocate or are in certain prescribed institutions or facilities.

**Mr Sterling:** One other question I had was, is it your understanding that the commission will be under the Freedom of Information and Protection of Privacy Act, controlled by that act?

**Ms Spinks:** It is anticipated that the commission will be designated as an institution to which it applies. The act has been drafted on that understanding. Obviously that designation has not taken place yet. There has been some concern about the application of FIPPA. That concern specifically is that under FIPPA, third parties can apply to obtain information from an advocate's file, information that's relayed from the individual vulnerable person to the advocate. It's our opinion that this information should be private. There is an amendment proposed that would exclude an advocate's case file—that is, a file he develops in the course of giving rights advice or providing individual advocacy—from the application of FIPPA. But generally speaking, the commission will be subject to FIPPA. For example, an individual could apply for general information concerning the policies, funding and general operation of the commission.

**Mr Sterling:** I would have looked at the alternative. My preference is that the commission be under the Freedom of Information and Protection of Privacy Act for the privacy protection under the act. Quite frankly, I don't look at the act as being all that overindulgent in giving out information. Therefore, I would rather have my file under the act than not under the act, if I had my druthers.

**Ms Spinks:** We could debate the specific provisions for a long time. But it's my view that the Advocacy Act's confidentiality provisions are narrower and stricter and protect the individual vulnerable person's privacy better than FIPPA.

**Mr Sterling:** Okay, that's fair.

**Mr Wessenger:** I have a question with respect to section 6. I was wondering if you might advise us of the reason for the amendment of subsection 6(1) from the previous draft.

**Ms Spinks:** The section of the original bill says, "A majority of the members of the commission shall be persons who have or have had a mental or physical disability, illness or infirmity." Two things were pointed out. First, it seemed rather anomalous that having had an illness would qualify one to sit on the commission, because everybody in this room would qualify. Second, the act is for and about vulnerable people. It's more consistent with the principle of consumer control, I think, that we describe the membership of the commission or who we want to have as the majority of the commission as persons who are or have been vulnerable.

**Ms Valentine:** To some extent it's a clarification of the original intent.

**Mr Wessenger:** Reading the definition of "vulnerable person," I just have some concerns about whether that might be too restrictive a definition. I'd like some assurance from a practical point of view that it would not be too restrictive a definition. That is my initial concern in looking at it.

**Ms Spinks:** Certainly the groups that are most interested in this and that will likely be participating in the nomination process, consumer groups, felt that this was a significant improvement over the old section. They may not be satisfied with it in its entirety, but they certainly feel it's better than its predecessor. I should also point out that it only refers to a majority of the membership. It would not exclude other people, people who do not fall into that category, from sitting on the commission.

**Mr Wessenger:** The only thing I would like is just some background information with respect to the aspect that it is a workable section; that's the only thing from a practical point of view.

**Ms Spinks:** I can say that we are assured and, as I say, the section does not perhaps go far enough to satisfy some of the groups which represent vulnerable people, but they feel it is workable, that it does in fact reflect the basic principle underlying the act.

**Mr Wessenger:** My basic concern is that there might be some people, for instance, who have a moderate or have had a moderate or severe mental or physical disability or illness, but who would not be vulnerable and might be disqualified from being members of the commission. That is under the definition. That's my particular concern with respect to the definitions, because I see some people who'd be very valuable sitting on the commission who might be excluded as not being within that definition.

**Ms Spinks:** Because the disability isn't severe enough?

**Mr Wessenger:** Yes.

**Ms Spinks:** Of course, on a plain reading of the act, the individual would have to fall within the definition of a vulnerable person. But I think, again, we should remember that this is only talking about a majority, that other individuals are not precluded if the appointments advisory committee should so choose.

**Ms Jenny Carter (Peterborough):** I have two questions. One is a very general one: Would you say that the amendments add up to a clarification and intensification of the original intent of the bill, or would you say that there's been change in direction on any point?

**Ms Spinks:** I think the changes are largely ones of clarification. I don't think we have deviated in any significant way from the basic principles and the basic intent. Ms Valentine or Ms Perlis might want to comment on that further.

**Ms Valentine:** Certainly I would reiterate that the basic policy and intent has not changed. Probably the only significant issue to point out would be again the issue of non-instructed and pulling that within the act rather than leaving it to regulations. All the other issues have been, I think, strengthening, tightening, clarifying the original intent.

**Ms Carter:** So that's a slight extension of what was included before. Otherwise, we're just clarifying and generally making the act more effective.

**Ms Valentine:** Yes.

**Ms Carter:** The other is in the region where this overlaps somewhat with Bill 109, which I know we're going to hear about later. I'm not clear what the function of an advocate might be, if there is a function, with respect to a person who is being declared incompetent, as might happen during the progress of Alzheimer's disease. For example, there might be a point beyond which the person is not fit to instruct, if you like. But is an advocate called in when that decision is being made?

**Ms Spinks:** Yes. Under both Bills 108 and 109, if the individual is alleged to be incompetent to make personal care decisions, manage his or her property or provide informed consent to treatment, then there is a role for an advocate, subject of course again to the amendments that will be brought forward, which most of you have already seen to Bill 109, which will circumscribe the provision of rights advice or perhaps allow it to be provided by other persons in some circumstances.

There are no changes to the advocate's function in the provision of rights advice and other advocacy services under Bill 108, other than those that may follow in an ancillary way from some of the suggested changes around the validation or the requirements for validation.

1750

**Mr Sterling:** As I'm going through this I'm finding a few more questions. The committee that's established under section 10—the minister establishes the committee to advise the commission—was going to include the health care providers and family members of vulnerable persons etc. What is the power of the committee, if any?

**Ms Spinks:** The committee's function is as described in section 10: to advise the commission. I think it's a very similar mandate to those of advisory committees that currently provide advice to the government—for example, the advisory council on disability issues, the advisory council on senior citizens, some of the advisory committees that are proposed for the public guardian and trustee under Bill 110.

**Mr Sterling:** There's nothing in here that requires the commission to listen, or there's no reporting function of the committee. Is there any budget for the committee? How does it function?

**Ms Valentine:** With regard to budget, any requirement would be required to be funded. So since it is a requirement that the committee be established, part of budget planning would take this into consideration and ensure there was a budget for the committee.

**Mr Sterling:** But you don't have anything in here. Maybe that is a policy question, but there's no reporting function in here. They don't have to produce an annual report. There's no reporting function.

**Ms Spinks:** I assume you're talking about the advisory committee.

**Mr Sterling:** Yes.

**Ms Spinks:** That is correct. There is no specific requirement.

**Mr Sterling:** I would like to see some kind of requirement that something be produced.

**Mr Sauvé:** I'd just like to add that in terms of a number of advisory committees, the actual terms of reference of the advisory committees are established by an order in council. The requirements for the advisory committee to the government in terms of disability issues are that the terms of reference, the reporting requirements and the disposition of the recommendations are spelled out by the order in council that sets up the advisory committee. That's not the exclusive case here, whether it's the advisory committee on French-language education or the Ministry of Health advisory committee on the assistive devices program. There again, it's set up by order in council with—

**Mr Sterling:** Yes, but most of those advisory committees are not contained in legislation, as I understand it. Most of them are advisory committees which the minister decides—

**Mr Sauvé:** Most ministry acts give authority to the minister to propose the establishment of advisory committees. It's usually under the authority of ministry acts.

**Mr Sterling:** I guess this is held out, though, as something that is going to keep the commission in line with regard to the wishes of those other interested parties. I'll be interested to hear what they have to say in terms of whether they would like some kind of reporting function spelled out as well.

**Mr Sauvé:** I think the fact it would be mandated by legislation would give it perhaps more clout than one that was established under a more ad hoc approach.

**Mrs Sullivan:** I hope this isn't a policy question, because I'd like some information about it.

I'm looking at clause 7(1)(c) of the combined bill, relating to systemic advocacy. One of the concerns I have is the understanding of what "systemic" means in that I think it's a jargony word. In fact, what is really being proposed is a method of promoting change in either programs or institutional approaches to issues. First, how do you see the advocate kicking in to do that? Second, with regard to the nature of change and the identification of needed change, how do you see the advocate working in the definition of those issues, if the voice is to be with the vulnerable person?

**Ms Valentine:** I'll address this, again from the experience of the psychiatric patient advocate office. I think I'll be able to address it quite concretely. Systemic advocacy essentially must be grounded in individual case advocacy. There would not be a proposal from a policy standpoint that suggested that systemic advocacy could/should occur completely independently of individual case advocacy. With regard to your question relating to kicking in, issues would be identified by vulnerable persons. Systemic advocacy may occur because a number of people raise the same issue. It could occur because an issue comes to an advocate's attention that clearly has a significant impact on a number of other people. It could be raised from community consumer



groups, where they're requesting assistance from an advocacy standpoint—voting issues, for instance. There are a number of ways it could come about, but it comes from the perspective of individual client consumers to start with.

The other issue is that the consultation role with consumers and consumer groups can frequently occur in systemic advocacy. That might vary to some extent depending upon what the issue was and what the setting was etc.

**Mr Sterling:** If I could just ask a supplementary on what you said about voting issues, would it be your anticipation that under this bill the commission would take a stand in a provincial election to support one party or another?

**Ms Valentine:** No, no, the right for people to be able to vote—I use that as an example because—no, it's not a partisan issue—it is a systemic example that came to mind. It's been in only the last few years that people who are in institutional settings have had the right to vote.

**Mr Sterling:** I want to know how to act on this act.

**Ms Valentine:** If you need help getting a voting booth in your nursing home or situations such as that, that is the type of issue I would be referring to.

**Mr Winninger:** Your party is definitely a vulnerable one.

**The Chair:** Order, please.

**Ms Spinks:** I'd like to just point out that we have taken out the reference to the word "political" and changed it to "governmental," because Mr Chiarelli certainly raised the point during the public hearings that it might lead to the conclusion you were suggesting.

**Mr Sterling:** One of the problems you can get into in these organizations is, how much advocacy are you doing for the individual and how much are you really into the systemic business? We faced it with the legal aid clinics some years ago. We'd have to pull them back on track every so often, or we felt we had to every so often, when they were spending too much of the resources in the one way rather than the other. There's no consideration as to what they have to do with their money.

**Ms Valentine:** No, there's not a requirement within the act. I suggest that the issue may evolve over a period of time. Likely in the beginning there would be more focus on client issues and there would gradually be an increase on the amount of systemic work done but with some sort of cap or limit on that, I anticipate.

I could again refer to the evaluation that was done of the psychiatric patient advocate office, and there was a strong recommendation that more systemic and non-instructed work should be done. That was after about three years of the program. Again, there is the concern often brought forward by consumer groups that if focus stays entirely on individual work, the changes never get made, that you keep addressing the same types of issues over and over and that systems don't really become better for disabled persons in that way. So the importance of systemic work really can't be discounted, but to suggest that there's a perfect balance or percentage—I have never seen it being

described in any literature on advocacy as an ideal percentage or ratio to be established.

**The Chair:** Thank you, Mr Sterling, for your brief supplementary. Mrs Sullivan.

**Mrs Sullivan:** What concerns me is the vagueness of this particular paragraph still. I think the reference, as I understand it, is really to programs and services provided by government, the legal system, the social services system and so on. Is that right, or is it further than programs and services?

**Ms Valentine:** No, it definitely could be further than programs and services. For instance, if there were a particular issue related to disability policy that the disability community felt required legislative reform, it could entail that type of governmental advocacy.

**Mrs Sullivan:** That would ultimately be a program delivery question, though.

**Ms Valentine:** It could be a program delivery question in the sense of absence of a program. I tend to think of programs as a specifically circumscribed program versus a large policy established that allows different programs to function.

**Mr Sterling:** I have one last question. The adult protection workers who came in front of this committee were very sceptical because of their experience. They said that what we need is an obligation on the government to react to the advocate. Most of the advocacy work with vulnerable people as they experienced it was not a problem with finding out what was right or wrong, or convincing or getting the vulnerable person to understand what he wanted or what she needed, it was a question of getting the government to react. Is there anything in the Advocacy Act which forces the government to meet its obligations as the advocate puts forward?

**Ms Spinks:** There is nothing there as suggested by the APSWs, no. I don't think it would be appropriate. In fact, I don't know if it would be effective or legal to legislate an obligation on the government to respond.

**Ms Valentine:** Could I add, however, that the requirement that a report be tabled in the Legislature on an annual basis provides the opportunity for a check and balance. Supposedly, three parties would hear the report or see the report and there would be the opportunity for questions etc at that point.

**Mr Sterling:** Just before we close, Mr Chairman, we may like to ask some questions of the staff after we deal with Bills 108 and 109. I'm not sure it will be necessary, but we've had some references to 108 and 109 and I'd appreciate it.

**The Chair:** I'm sure they'll make themselves available if need be.

**Ms Spinks:** Absolutely.

**The Chair:** Seeing no further questions or comments, Ms Valentine, Ms Spinks, Ms Perlis and Mr Sauv , on behalf of this committee I'd like to thank you for taking the time out of your busy schedules to come in and give us your presentation today. This committee stands adjourned until—oh, Mr Sterling.



**Mr Sterling:** To Ms Swift, our researcher, we haven't had an opportunity to match up the amendments the government has brought forward with the various requests or concerns we have heard from the various groups. Are we doing that, or are we attempting to do that, or is that a possible task?

**Ms Swift:** It's possible. The time frame would depend on how the committee is going to be proceeding, but it would take some time. I could do that if you wanted, if the committee requested me to do it. I haven't undertaken that task.

**Mr Sterling:** I would appreciate at least seeing the lining up of the various sections that a particular group was concerned with against what the government has proposed;

not necessarily saying whether the government's amendments have met the concerns, because I think that would be a judgemental part of it, but I would appreciate that. I don't know whether other members of the committee would like it or not.

**Ms Swift:** I certainly could do that.

**The Chair:** I'm sure that would be very useful to the committee.

Seeing no further business before the committee this afternoon, we stand adjourned until immediately following routine proceedings tomorrow.

The committee adjourned at 1805.









## CONTENTS J-4

Monday 25 May 1992

<b>Advocacy Act, 1992, and companion legislation</b> . . . . .	<b>J-11</b>
Office of Disability Issues, Ministry of Citizenship . . . . .	<b>J-11</b>
Mary Beth Valentine, advocacy project leader	
Clément Sauvé, senior adviser	
Trudy Spinks, ministry counsel	
Linda Perlis, ministry policy analyst	

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J-5

J-5

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Deuxième session, 35<sup>e</sup> législature

## Official Report of Debates (Hansard)

Tuesday 26 May 1992

## Journal des débats (Hansard)

Mardi 26 mai 1992

### Standing committee on administration of justice

Advocacy Act, 1992,  
and companion legislation

### Comité permanent de l'administration de la justice

Loi de 1992 sur l'intervention  
et les projets de loi  
qui l'accompagnent

Chair: Mike Cooper  
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Président : Mike Cooper  
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## **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

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## **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Tuesday 26 May 1992

The committee met at 1537 in room 151.

### ADVOCACY ACT, 1992, AND COMPANION LEGISLATION LOI DE 1992 SUR L'INTERVENTION ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervenants en faveur des personnes vulnérables; Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne; Bill 109, An Act respecting Consent to Treatment / Loi concernant le consentement au traitement; and Bill 110, An Act to amend certain Statutes of Ontario consequent upon the enactment of the Consent to Treatment Act, 1992 and the Substitute Decisions Act, 1992 / Loi modifiant certaines lois de l'Ontario par suite de l'adoption de la Loi de 1992 sur le consentement au traitement et de la Loi de 1992 sur la prise de décisions au nom d'autrui.

#### MINISTRY OF THE ATTORNEY GENERAL

**The Chair (Mr Mike Cooper):** I would like to call this meeting of the standing committee on administration of justice to order. We will be continuing with our briefings. Today we will be starting off with Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care.

I would like to welcome Mr Fram, our presenter. Could you please identify yourself for the record. You'll be allowed about half an hour for your presentation and then we'll open it up for questions and comments from each of the caucuses.

**Mr Steve Fram:** I'm Steve Fram from the Ministry of the Attorney General. In spite of the many years of consultations that have gone on previous to the introduction of Bill 108, the Attorney General knew when he spoke to you last December that the process was not complete and that organizations and individuals would be appearing before you to challenge the concepts in the bills. He undertook to you to have staff available during the 17 days of public hearings to listen to those submissions, analyse those briefs and propose for the government changes to the bill.

There are 82 government motions for changes to Bill 108. While many of these motions are technical changes to achieve consistency of language, I believe you will see reflected in the motions the sense of what you heard during the 17 days of public hearings. There are motions that propose changes to respond to some of the specific requests

about details of the bills from organizations like the Ontario branch of the Canadian Bar Association, the Ontario Hospital Association, the Ontario Medical Association and AIDS Action Now. However, most important, there are government motions designed to make three changes that will have a very important effect on how the legislation will work for people.

The first set of proposed changes is found primarily in subsection 47(9) and subsection 47(9.1) of the reprint, at the bottom of page 23 and on page 24. These changes, and the side note "Authority before validation," are designed to meet concerns we heard from several advocacy and seniors' organizations and Madeleine Honeyman that the requirements that powers of attorney be validated before they were effective would deny grantors the ability to rely informally on trusted friends and family as their capacity diminished. In short, there was too much formality in Bill 108 about situations where there is no conflict.

The challenge was to permit reliance on powers of attorney while protecting the grantor from losing his or her autonomy when the grantor did something the family didn't agree with, like getting a friend of the opposite sex in his or her senior years, a frequent source of family disputes.

The key to the provision was provided by Patrick Worth of People First of Ontario. He clearly defined the line at which support stops and loss of autonomy begins. He said that the right to stop a decision by saying no ensures that power remains with the individual.

Subsection 47(9) provides that under an unvalidated power of attorney for personal care an attorney can make a decision concerning the grantor's personal care in accordance with the requirements set out. If you will look at those requirements, they begin at the top of page 24.

"(a) the attorney has reasonable grounds to believe that the grantor is incapable of making the decision;

"(b) the attorney explains to the grantor,

"(i) the need for the decision,

"(ii) the decision the attorney intends to make, and

"(iii) the right of the grantor to object to the decision; and

"(c) after receiving the explanation required by clause (b), the grantor does not object to the decision."

Thus, people in their periods of declining capacity or people who never had capacity to make the decision in the first place—and you'll see that in the next major change—can retain control by being able to say no and yet allow a family member to consider the decision and make the decision. Many family members will go with the trusted choices of their family.

**Mr Norman W. Sterling (Carleton):** If I can I ask a specific question, how do you prove that has been done?

**Mr Fram:** It's a duty of the attorney. The attorney makes the decision. If somebody takes it up, he would have to establish that he did the explanation.



**Mr Sterling:** So a witness that it had been done in writing or something like that.

**Mr Fram:** Subsection 47(9.1) provides that, except as provided in the Consent to Treatment Act, which has its own protections, an unvalidated power of attorney cannot be used to override the objection of the grantor to a decision by the attorney. That is the first major effect, and it will in fact provide for a great amount of informality in non-contentious issues, something a lot of people were looking for.

The second of the proposed changes that will have a major effect is set out primarily in the proposed new section 47.1 on page 24 of the reprint, which sets out the capacity to make a power of attorney for personal care. The committee heard from a number of organizations for community living and from several organizations under which adult protective service workers provide services to adults with cognitive impairments. They spoke against the need for guardianship and in favour of supportive decision-making. They told us of people who have been able to get by with community support without guardianship. It's been the view of every Attorney General who has considered substitute decisions that guardianship should be a last resort.

The key to the provisions came in the proposal of the Ontario Advocacy Coalition. It recommended the provisions of a standard of capacity to make a power of attorney for personal care that will permit far more people to choose their own substitute decision-makers. The proposed new section 47.1 would allow people to appoint an attorney for personal care if they are able to understand that the person proposed as attorney has a genuine concern for their welfare and to appreciate they may need the assistance of someone to make their personal care decisions.

Under this proposal, people who cannot make a specific personal care decision themselves would be able to choose someone to make the decision for them. Thus, supportive decision-making can take place. This is not unlike what most of us do when we're required to make a decision about a matter requiring expertise. We choose someone to make the decision, but retain the right to say no to the choice. When combined with the first proposed major change, making unvalidated powers of attorney effective, it means that for almost everyone at almost any stage of their adult lives they would be able to choose someone to lean on to make their decisions for them. It means that if they do not like the decisions, they can say no.

Through this change, parents with an adult child who has a developmental disability will know the network of support they've helped to put in place will be able, with the approval of the person who is supported, to continue that support. It will permit the support network to work with a minimum of formality and ordinarily without state interference. It will permit care givers to receive the authority to act. The public guardian and trustee will be able to focus his or her attention on those who have no support network or where things go wrong.

Some members of the committee may wonder whether there are sufficient safeguards, especially in light of the ability attorneys will have to make decisions without validation. First, you have to look at the kinds of decisions that

are involved. We're talking about personal care decisions: health care decisions, nutrition, shelter, clothing, hygiene and safety. It should be noted that the lower threshold of capacity does not apply to capacity to make continuing powers of attorney for property decisions.

What's the situation now? Except for treatment decisions in hospitals and psychiatric facilities, there are no laws permitting personal care substitute decision-making, other than guardianship or committeehip under the Mental Incompetency Act, and they're very few. Substitute decisions are made now for people who are mentally incapable by people who are acting without authority and without any safeguards.

What safeguards are there? For treatment decisions, Bill 109 will apply. The Consent to Treatment Act would provide that before an attorney under an unvalidated power could make a substitute decision, a health care practitioner has found the grantor incapable of consenting to the particular treatment, has proposed and explained the treatment and has determined that the grantor does not object to the treatment, and where the treatment is a controlled act—and you'll hear more of that from the Ministry of Health representative—where the grantor objects to the treatment, the practitioner has called on a rights adviser.

Possible concerns about treatment interruptions in psychiatric facilities and hospitals, if a treatment-incapable grantor appoints an inappropriate attorney, are addressed by a proposed amendment to the Consent to Treatment Act to provide that under these circumstances a new attorney does not have authority over the treatment, unless the attorney is approved as the patient's representative by the review board.

#### 1550

Other safeguards: The grantor's objection would bar the attorney making a decision; the grantor's right to revoke the power. A new subsection 47.1(2) would provide, "A person is capable of revoking a power of attorney for personal care if he or she is capable of giving one." Thus, if the grantor no longer trusts the attorney, the grantor can revoke the power.

The grantor's right to block validation: Only attorneys with powers that have been validated will have authority to override the grantor's objection. Before validation takes place, there is a required visit from an advocate to ascertain if the grantor objects to validation.

The public guardian and trustee's scrutiny of validation: If the PGT is given reason to believe that the attorney is not acting properly, the PGT can refuse to validate. That's subsection 49(9).

The presence in facilities and the community of advocates: Those care givers, family and neighbours who are concerned about decisions by an attorney can inform the advocate.

The rights of family and the PGT to apply for guardianship: Section 52 applies.

Finally, the public guardian and trustee's duty and power to investigate an act and act on allegations that the grantor is incapable and is at risk of serious adverse effects: In reality, most of the people, the family members, who surround people who have disabilities are very supportive. They make decisions now. This will permit the person



who's receiving the support to designate the person, the family member, the part of the network that he or she believes in and trusts to make those decisions. It will keep the state out of those matters that are consensual by nature.

Subsection 47.1(2) provides that if a person—we've already done that—can make the power of attorney, he can revoke it.

**Mr Sterling:** Could I ask a question? We're getting into a lot of different circumstances and we have the introduction of a new concept here. We have the concept that a person is capable of giving a power of attorney to personal care where he normally wouldn't be able, under our old law or the previous bill, to have capacity to do that. So there are two kinds of people who could be giving powers of attorney for personal care. There are those who are perfectly competent, if you want to put it that way, or those who are not competent or wouldn't be deemed competent for a power of attorney dealing with property assets. This sets a lower standard so that people could give a power of attorney for personal care.

Where is the limitation? I'm concerned about that to some degree. Once you lower the standard, then the vulnerable person could be taken advantage of by any number of people inside or outside the family or whatever. Are the added safeguards that you're putting in peculiar to that lower standard, that lower test? In other words, when the person makes a power of attorney, do they say he's class 1 or class 2?

**Mr Fram:** No.

**Mr Sterling:** So they're all the same group?

**Mr Fram:** They're all the same group. We all make mistakes in whom we choose to trust.

**Mr Sterling:** Yes.

**Mr Fram:** The divorce rate proves it.

**Mr Sterling:** Notwithstanding that, you worry about it. Presumably the person who is more competent, if you want to put it that way, would rectify that upon losing the trust. Perhaps somebody in this situation under the minor test would not take immediate steps to rectify that situation. So they all come under the same test, but then you say it depends on how that power is used as to whether it must be validated or not. Is that correct?

**Mr Fram:** It needs validation only if it's going to override the objection of the grantor. If, for example, the attorney says, "You're going to live in X group home," and the grantor says no, that decision doesn't stand. Those are the main kinds of decisions that come up. We're talking about safety concerns. We're talking about hygiene concerns. In connection with health care, there is a whole other set of safeguards in that you have a practitioner there who is controlled, himself or herself, by a code of ethics, standards of care. You have a review board to go to in case of objection.

When you think about the kinds of personal care decisions and the things that make major changes in peoples' lives, the ability to say no—the most serious cases will be either in a home setting or a facility setting where there are people to hear the no.

**Mr Sterling:** I'm sorry. Could you—

**Mr Fram:** Okay. Subsection 47.1(3) is very important. It applies a higher standard of capacity for instructions contained in a power of attorney. In essence, the grantor must be able to understand the information relevant to a decision about care to put instructions in his or her power of attorney for personal care, so you have that additional protection. The witnesses are to inquire whether people understand the instructions they are putting in their powers of attorney. That safeguards in two ways: It makes the instructions more valid to act on later for the family members, the person named as attorney, and it also protects against potential abuses using instructions.

The third of the significant changes proposed in the government motions is provision for expedited validation, set out primarily in new sections 50 and 50.1 of the redraft, page 26. During the course of the public hearings you heard from families of people with schizophrenia and other mental disorders. Most eloquently you heard from Bob Walsh who has such episodes and wants a means of ensuring that while he's capable he can take steps to ensure he will get the care he needs and believes he wants when he becomes incapable. You were informed there is no assurance under existing law, or indeed under Bill 108 without the changes proposed, that can be given to Mr Walsh. The Ontario Friends of Schizophrenics appeared before the committee and recommended amendments to Bill 108 to provide a power of attorney that would give Mr Walsh that assurance.

The proposed new section 50 would establish a procedure whereby a person who experienced episodes of mental disorders can, while mentally capable, appoint someone as attorney and give the attorney authority to get the grantor the kind of treatment the grantor has specified over the grantor's incapable objections during an episode. The procedure will ensure that the grantor fully understands what he or she is doing in making the power and that the attorney gets these powers only when they're needed. It has safeguards that protect against abuses without reducing the effectiveness of the power of attorney.

1600

Subsection 50(2) provides many of the unique features. The grantor can provide for the attorney causing him or her to be professionally assessed for capacity when there is an episode. The grantor can set out factors to be considered by the assessor in determining whether the grantor is incapable, for example, things the grantor knows when mentally capable but does not know when mentally incapable. The grantor can authorize the attorney and those assisting the attorney to use reasonable force when necessary to get the grantor to an assessment. The grantor can authorize the attorney to use reasonable and necessary force to take him or her to a place for the care he or she has specified.

The safeguards are of vital importance. The grantor must be assessed as capable of personal care when the power is made. Unlike ordinary powers of attorney, which are merely witnessed, this would require an assessment of capacity at the time of making it. The power must be registered with the public guardian and trustee and the person, the grantor, visited at that time by an advocate, advised of his or her rights and his or her desire to have it registered



confirmed. That is, the person must want to have it registered. There must be one assessment of incapacity before it comes into effect. While it comes into effect, when the assessment finds the grantor incapable of personal care, the grantor is still under a duty to file the assessment with the public guardian and trustee and file a plan of guardianship.

The proposed new section 50.1 provides for validated attorneys ceasing to be validated on the assessment that the grantor is capable of personal care. Under subsection 50.1(1) the attorney must arrange for assessments at the grantor's request, but unless the attorney believes the grantor is now capable under 50.1(2) there need not be more than one assessment every six months. Subsection 50.1(4) requires the attorney to notify the public guardian and trustee of the assessor's statement of capacity. Unless the grantor revokes the power of attorney when he or she has been found mentally capable, it can be validated again if incapacity again arises. So it can be a device to protect you against episodes that come up from time to time and will stand by you in those times unless when you're capable you revoke it. That is a major change, and no jurisdiction of which I'm aware has provision for both what might be called a Ulysses contract plus the safeguards on its use. It's in use in many jurisdictions in the United States, sometimes without any legislative sanction, but there are no safeguards of this kind on the use of the power.

Those are the three major effective changes. There's one other change I should bring to your attention. It's neither a small adjustment nor a major change. It was clear from the briefs of such organizations as the Advocacy Centre for the Elderly and the Psychiatric Patient Advocate Office that there is a great need for the public guardian and trustee to investigate and take necessary action on allegations that someone is mentally incapable and is being financially exploited or suffering illness or injury or deprivation of liberty or personal security as a result of the incapacity. It was also made clear that there must be authority for the public guardian and trustee to investigate and obtain records in these circumstances so situations where the allegations are false can quickly be determined and prompt applications to the court for temporary guardianship can be made where the allegations are true.

The proposed new sections 78.1 and 78.2, pages 48 to 52, provide those provisions. They give the public guardian and trustee significant powers to investigate allegations. The provisions themselves should look familiar, since they're modelled on those in the Advocacy Act.

Sections 27 and 59 of Bill 108 impose on the public guardian and trustee the duty to investigate all allegations and the duty to apply to court for temporary guardianship if there are reasonable grounds to believe the allegations are true. However, when Bill 108 was introduced the duty to investigate was not complemented by investigative authority.

Allegations of incapacity and serious harm are frequently made by those who are well-meaning but misinformed, such as neighbours, and those who have improper motives for seeking the intervention of the office—for example, family disputes over a parent granting a power of attorney to one child but not another, gifts to one child

excluding others, or adult children against a parent's new spouse. Allegations invariably describe heinous abuse, neglect and exploitation and are accompanied by a prediction of grave consequences if the office fails to intervene immediately.

It is extremely difficult, if not impossible, to get information necessary to decide whether the PGT should intervene. Sometimes those at serious risk are reclusive or held captive by others who block all reports or efforts to obtain access to the individual. Lawyers, health care workers, financial institutions and government bodies are reluctant to provide information, and they're often constrained by confidentiality rules from providing information.

Subsection 78.1(1) confers on the public guardian and trustee a right of entry limited to the purpose of an investigation under sections 27 or 59. This is all designed to get a meeting with the person alleged to be incapable. While it doesn't determine the matter, it's the single most important investigative tool. It will frequently be found that there is no question that the person is in fact fully capable. One frequent type of situation is where an older person with grown children starts to do anything that's different. All sorts of emotions boil over in the children when a parent seen in one role for a whole lifetime takes an initiative to change his or her life. A visit from the PGT's office to talk to the parent will often be enough to discontinue the investigation.

Subsections 78.1(2) and (3) entitle the person doing the investigation to get into the common areas of a facility or a controlled-access premise. It should be noted that access to a private dwelling unit is only with the consent or acquiescence of the occupier or with a warrant, except where warrants can't be obtained. Subsections 78.1(4), (5), (6) and (7) deal with the details of the warrant: when it may be issued, limits on its use, limits on its duration and permitting the PGT to call on the assistance of the police to enforce the warrant. Subsection 78.1(8) deals with the warrantless entry when it is impractical because of the location of the premises to obtain a warrant for a necessary visit. Subsection 78.1(9) requires a meeting without interference and in private. This is vital for those situations where someone is being confined or coerced. Subsection 78.1(10) requires the PGT to leave promptly when requested to do so by the allegedly incapable person.

Subsection 78.2(1) is designed to provide the PGT with access to a wide variety of records for the purpose of an investigation. Without the provision, much of the information would be confidential and unavailable. On the financial management side, records of financial institutions, records of dealings with bank accounts, pension funds and listing agreements for houses are vital to making a decision about applying for temporary guardianship. On the personal care side, health care records and facility records are vital to making a decision on whether to intervene.

1610

Subsections 78.2(2) and (3) are limitations on access. Solicitor-client privilege prevails and law enforcement privilege prevails. Subsection 78.2(4) provides the rules for when the PGT is entitled to access. Subsections (5), (6), (7) and (8) address the obtaining and use of the warrant to gain access to records. Subsection (9) prohibits the



PGT from disclosing the information in clinical records of a psychiatric facility except as provided in the Mental Health Act. Subsection (10) makes all provincial and municipal government records available—for example, family allowance and other welfare records—despite confidentiality provisions elsewhere.

Proposed new subsections 27(10) and 59(12) direct what the PGT must do when he has done an investigation and decides that no application for temporary guardianship will be made. First, he must destroy the information. Then he must notify the person investigated that an allegation was made, that the PGT investigated and decided not to act and that the information collected has been destroyed.

I'm pleased to answer any questions you have about these or any of the other government proposals for change to Bill 108.

**Mrs Barbara Sullivan (Halton Centre):** I don't know if you've seen the Hansard from yesterday, but I think it was clear that we saw some of the proposals for change in these bills as being useful ones. You will understand, with the volume of amendments that have been put forward, even by members of the government party, let alone members of the opposition or of the groups and agencies who have had a particular interest in following the course of these bills, that the analysis is not yet complete.

There are some issues I want to put to you for clarification in terms of amendments on Bill 108. One of them relates to the fact that you've left the assessor still under the regulations to be made latterly. I think one of the things that came forward and that people were concerned about during the hearings related to the consistency in the assessment techniques and the opportunity for revision of the assessment on a regular basis in the training and guidelines for assessors. They are still not very clear under the bill.

I'm not sure if this is a policy question or not, but I wonder why they have not been made more clear in the bill. I've got other questions relating to assessors as we go on.

**Mr Fram:** I hope this isn't a policy issue. First of all, there's no place we can take the assessment provisions from. No one has provisions for doing proper assessments. It's not like you can borrow expertise from other jurisdictions. The second part is that until bills are enacted, money is seldom available to do all the work that's necessary to achieve it. Some preliminary work has begun. We have a general notion of where it's going, but until those things can be tied down you can't make those decisions.

We have a situation under existing law where there is no existing standard for assessments. It goes all over the place. We know we want a consistent standard. We have preliminary work that was done by David Weisstub on competency assessment. We have been looking at ways of bringing that into effect so that existing professionals can be accredited to do the assessment, but we haven't yet gone far enough to be able to put anything down other than in regulations. It may change over time. It's another one of those things we're going to have to gain knowledge on as we go along and perhaps improve standards.

**Mrs Sullivan:** This was an area that was addressed by several groups and organizations. I think there were questions

relating to this on the very first day these bills came to committee. I think it is a matter of some concern that we have legislation where a major part of the functioning of that legislation is left in a vacuum.

Yet throughout the bill this entire assessment question—particularly Bill 108 but also the consent to treatment bill—is affected by the nature of the quality, training and specifications for the individuals who are going to be making decisions. I look, by example, at—

**Mr David Winninger (London South):** On a point of order, Mr Chair: I thought we had agreed to this forum to allow our experts from the ministry to come and give information on the amendments to the three acts. I'm listening very patiently to Mrs Sullivan, but what I'm hearing her embarking on is an analysis of policy decisions that are being made. I can't understand why we need to waste the valuable time of this committee when these concerns can be expressed as we're doing the clause-by-clause. I think questions should be put to the experts from the ministries, which they certainly have the expertise to answer, but I hear Mrs Sullivan making a statement on assessments that clearly isn't one designed to add any information to the committee.

**The Chair:** The committee did agree to the briefings. Sometimes the policy comes into effect during the briefings. If Mrs Sullivan gets way out of order, then I will call her out of order.

**Mr Winninger:** Then I would suggest, if we are embarked on an analysis of policy, that those questions be directed to the parliamentary assistants. Certainly Mr Fram is well-equipped to handle informational questions, no doubt about it.

**The Chair:** As I stated yesterday, if it was a policy question and the parliamentary assistants decided they wanted to answer, they'd be free to answer if they chose. Mrs Sullivan.

**Mrs Sullivan:** I will continue in relationship to questions on assessors. Under subsection 46(10) the grantor can name assessors. If this bill receives royal assent and comes into effect, at that point we will have no method of determining who those assessors are or what the standards are. Am I correct? What you're telling us is that there will be a length of time before those regulations would be available.

**Mr Fram:** That's correct. There will be some gap.

**Mrs Sullivan:** In other words, some of the rights that are provided through the changes will not be available.

**Mr Fram:** Parts of the bill could be proclaimed before, for example the provisions providing for prescribing who the assessors are and the training of those assessors. It would be possible to do that before the rest of the bills came into effect.

1620

**Mrs Sullivan:** I'd like to look at subsection 46(10) in particular, with a similar question on the same issue of assessors and the right of the grantor to select an assessor. I'm sorry; I just can't remember the exact section. If a person is capable, having provided a power of attorney, that person is capable of revoking the power of attorney. It



appears to me that subsection 46(10) would enable a person, whether capable or incapable, to select an assessor. Is that what was intended by that subsection?

**Mr Fram:** Subsection 46(10), in fact the person would have to be capable of making—I guess this is subsection 47(10) that you're really referring to?

**Mrs Sullivan:** I guess there are two sections that refer to this same area, but subsection 46(10), the grantor is enabled to—oh, sorry, just a minute. Yes, you're right, subsection 47(10). I forgot about that section 47.1 business. Subsection 47(10), the grantor can name preferred assessors in a power of attorney, but there isn't the same written obligation for the grantor to be capable at the time the assessor is named.

**Mr Fram:** But only a person who is capable within the definition of subsection 47.1(1) can make a power of attorney, and that person could name a preferred assessor.

**Mrs Sullivan:** Okay. That's good then.

Now, subsection 47.1(3), once again in relationship to the instructions and the capability: One of the things that became an issue during the hearings related to the fact that medical treatment changes and approaches to dealing with injury disability or other circumstances change. In the pre-instructions, instructions contained in a power of attorney for personal care while the person is capable are to be executed, provided that the grantor had the capacity to make the instruction, that the grantor was capable at the time. Is there, in bringing this bill together with Bill 109, the facility for an override in the patient's best interests if circumstances had been substantially changed as a result of a change in medical technology or whatever?

**Mr Fram:** Yes, I think the answer to that lies in Bill 109 where the provisions have been revised, and there is further ability to go to the board about questions about which there is doubt, and that's an excellent question.

In any event, we have revised subsection 63(3)—that's on page 36 of the reprint—so the issue is always if the guardian knows of a wish or instruction applicable to the circumstances. Now, owing to circumstances many wishes may become outdated and not applicable any more, so one of the key criteria is applicability.

Again, paragraph 63(3)3 deals with a later wish or instruction expressed that prevails, and paragraph 63(3)4, if there's no wish or instruction that's applicable to the kind of decision in the circumstances, the substitute must make a decision in the person's best interests. So the issue of applicability is a crucial one, and as I said, even when it's applicable, there are provisions to go to the review board when there's doubt in a treatment decision under Bill 109.

**Mrs Sullivan:** Does that apply to a power of attorney that has been pre-validated?

**Mr Fram:** It would apply to any substitute decision-maker under Bill 109.

**Mrs Sullivan:** Okay. Is there any clarification in the amendments that the same person can be designated as a power of attorney for personal care and for property and as a guardian?

**Mr Fram:** While somebody might be confused, the standard rule of law is that if a thing is not prohibited, it's permitted, and there's no prohibition in the bill. It's hard to state all of the affirmatives that are true in legislation. I think it would become much clearer in the form where you'll have them side by side with instructions, but going down the page, combining a continuing power of attorney for property, preceded by the power of attorney for personal care, and people being able to fill in what they want. That follows the American Bar Association model.

**Mrs Sullivan:** Okay. If there is a conflict between attorneys for personal care or property care or a guardian where the expenditure of funds is necessary, what is the resolution process?

**Mr Fram:** Section 80 says the public guardian and trustee can mediate those kinds of disputes, and in both the property section and the personal care section there are provisions for going to the court for directions.

**Mrs Sullivan:** If there's a personal care decision where immediate treatment is seen to be necessary in the best interests, what is the situation if there's a time lag in the application either to the PGT or to court?

**Mr Fram:** I'm sorry. I don't understand the question.

**Mrs Sullivan:** If there's a situation where a person in fact needs an expenditure for personal care—by example, there is a dispute between the nature or extent of the funding that the property care attorney would provide or should provide—the issue goes to the PGT or to court.

**Mr Fram:** You have a mean-spirited property guardian and someone in his dying days wants a trip to Disney World or some such thing that can make his life a little bit happier.

**Mrs Sullivan:** It may not be mean-spirited.

**Mr Fram:** It would be up to the public guardian and trustee, but he could apply under the provisions for temporary guardianship. He would then be able to apply on notice for a quick decision by the court.

**Mrs Sullivan:** Okay. Section 52: I have factors described in that section. This is a new section to the bill. What kind of factors could be included?

**Mr Fram:** I'm sorry. I'm not on the section.

**Mrs Sullivan:** Yes, it is the wrong section. I'll find it here in a second. Okay, this is once again back at the assessor. It's paragraph 50(2)2: "An assessor who performs an assessment of the grantor shall consider factors described in the power of attorney." What would be the nature of those factors?

**Mr Fram:** The factors described in the powers of attorney refer back to section—they may be symptoms. For example, if I'm doing this or reacting this way, it is a sign that I'm incapable. Or if this is the kind of behaviour I engage in, it's not the kind of behaviour I engage in when I'm capable. It will vary enormously from individuals, but in fact it would be symptomatic of that person's incapacity and his or her episodic disorder. I couldn't find any other way of describing it.

1630

**Mrs Sullivan:** Yes. It is very loose, though, I think.

**Mr Fram:** Since it only has to be taken into account by the assessor in doing the assessment—

**Mrs Sullivan:** If you know what the assessor is qualified and capable of doing.

**Mr Sterling:** I'm trying to work through here and figure out just what options people have with regard to the amendments you've proposed. At first blush, the best I can get is that you have the choice of making either a validated or an unvalidated power of attorney for personal care. I don't want to deal with the business one at all. You haven't changed any of the laws surrounding that, as I understand.

**Mr Fram:** Not significantly.

**Mr Sterling:** So you have the choice of making either a validated or an unvalidated—from what I read in terms of the requirements for a validated power of attorney, it's a pretty onerous task to go through. Therefore, we're really asking people to make an unvalidated power of attorney. Is that correct?

**Mr Fram:** In the ordinary case, people will not want to give someone else power to override their decision. So most people will want the right to say no later on. The exceptions will be people who have episodic disorders and some people in the early stages of Alzheimer's who know the declining state they will inevitably go into.

**Mr Sterling:** The duty to follow these powers of attorney by the health care profession: How is that going to be fleshed out?

**Mr Fram:** Bill 109 picks up the provision for powers of attorney. That is, if you have a validated power of attorney or a court appointment as guardian, you are the person who makes the decision and they won't coexist. You have a validated power of attorney, an unvalidated power of attorney or you have neither.

**Mr Sterling:** I'm talking about an unvalidated power of attorney.

**Mr Fram:** Right.

**Mr Sterling:** I think 99% of the powers of attorney are not going to be validated.

**Mr Fram:** That's right.

**Mr Sterling:** I think that's the right way to go. The other system was just too cumbersome to encourage people to do this. I guess what I'm worried about—not worried about, curious about—is when the power of attorney is presented by one family member. The unvalidated power of attorney to the health care professional and the other sibling or relative or whatever says, "That's not valid," or starts to attack the power. What does the health care professional do? They have to just—

**Mr Fram:** They would have to take the person—if you have a choice, the person with the power of attorney is the person. That's what the list says. Now, there is a new duty proposed in these amendments to consult with other members of the network. The attorney is under a duty to talk to the other siblings about the situation, to talk to other people who have retained contact with the grantor. In making

a decision the practitioner can say, as he would do now in those circumstances: "I'm expecting the answer from John, but would you all go away and talk about it, then come back to me, John, and give me an answer on this?" I think it's quite a practical kind of thing.

**Mr Sterling:** In terms of the validated power of attorney—which is a pretty powerful document because it basically says you're giving somebody else the right to override at a later time what you decide—I'll be interested to see what other people have to say about time limitations and the reassessments and all those kinds of things. I don't know whether they're practical or impractical, but I hope we can garner some wisdom from the witnesses on it.

I assume the validated power of attorney will be in the hands of the attorney, that he will walk into the hospital and say, "I want this treatment for this patient." If there's some question about that validity, how will the health care provider know?

**Mr Fram:** The other issue is that the proposal requires the public guardian and trustee to establish a register of validated powers of attorney, registered powers of attorney, and several guardianship orders made by the court and so forth. The register is accessible by the hospital, for example. They would be able to check with the public guardian and trustee's office that it was registered and what the terms of the power were, so they would have another means of addressing that issue.

**Mrs Sullivan:** Would the assessment also be registered?

**Mr Fram:** The fact that there was an assessment and it had been validated would also be registered.

**Mr Sterling:** Maybe I'll ask the parliamentary assistant this one. If you have a will, for instance, in Ontario and you want to have it kept somewhere—I don't know if it's changed now, I haven't practised law for so long—you used to be able to register it down at the registry office or at the county court office, it used to be, whatever, or the surrogate court office. Is there any provision for registering, as opposed to a valid will, an unvalidated attorney? Was that ever considered or do you think it would be just too cumbersome to do that?

**Mr Winniger:** I know what you're referring to, because traditionally if you wanted to deposit a will with the probate court, that would be public notice of the existence of the will. I may have to turn this question back to Mr Fram since he has the history with this concept of a registry.

**Mr Fram:** It was considered and just would be too cumbersome, because you want people to be able to change their minds and choose a different child.

**Mr Sterling:** I just worry about two of them walking in with two different ones.

**Mr Fram:** We did provide that the later one revokes the former one.

**Mr Sterling:** Okay. Do the amendments place more or less burden on the public trustee?

**Mr Fram:** I think the bill is far more focused. As I recall, it was your concern that we were doing things under Bill 108 that were unnecessary and wasting the resources.

**Mr Sterling:** That's right.



1640

**Mr Fram:** I think the focus is much more on things that go bad, that is, when somebody is mentally incapable and is suffering serious adverse affects as a result, the resources of the office will be much more focused on that, because where there is family, where there is a network, without even going to court you will be able to have an authorized substitute decision-maker. You don't have to use the resources of the public guardian and trustee reviewing private applications, exhorting people to get them, so you can focus on the two aspects: those who have no family network—and there, part of the effort should be trying to build a network around people—and the second part, when things go really bad, making applications for temporary guardianship.

**Mr Sterling:** We talked about the duty of the witness in terms of signing this personal power of attorney. In terms of when the treatment is given under an unvalidated power, who's going to measure whether a no has been said or not? Is it just going to be a straight evidentiary matter? I don't know, quite frankly, how the issue would arise.

**Mr Fram:** Under the Consent to Treatment Act, it's relatively simple because you have a practitioner there and the practitioner has a duty to find out if the person objects before any rights advice or anything else. That's pretty straightforward. That "no" can be overcome, but it's pretty straightforward. There are only so many major decisions, like not having baths if you're in a nursing home. Again, there will be a lot of what there is now, a lot of effort to get the person to do things, and that's what we want. We want less coercion and more persuasion. But the staff will know when the person is saying no.

**Mr Sterling:** My last question is that if the person is incapable you can go to the courts for a guardianship, as you could under the other bill. There haven't been significant changes to that?

**Mr Fram:** No.

**Mr Sterling:** You could have either a family member appointed as a guardian or have the public trustee and guardian, and that's all there is?

**Mr Fram:** No. You could have anyone who's willing and appropriate apply to be guardian. It's even possible to have an organization provide guardianship services if they became necessary.

**Mr Sterling:** Okay. Thank you very much.

**The Vice-Chair (Mr Mark Morrow):** Thank you very much, Mr Sterling. Mr Winninger.

**Mr Winninger:** I get to ask the tough questions. You referred to the new section 50 as a "Ulysses" clause. Someone the other day asked me, "Why do you call it a 'Ulysses' clause?" I said, "It's 20 years since I read Homer, but I'll ask Mr Fram." This seems like a good opportunity.

**Mr Sterling:** Is this a policy question?

**Mr Winninger:** Touché.

**Mr Fram:** Ulysses was out sailing with his men, and he had a fatal attraction to the sirens' call. That's around

Sicily; there's a small island with a great number of shipwrecks and seamen were lured for generations on to these rocks. Ulysses said to his men, "I know I can't resist them, so when we get near there and I hear them, tie me to the mast and disregard all my orders until we get by." That's why this has had the Ulysses connotation.

**The Vice-Chair:** Thank you for that, Mr Winninger. Thank you very much, Mr Fram.

#### MINISTRY OF HEALTH

**The Vice-Chair:** I'd like to call forward the officials from the Ministry of Health for Bill 109, An Act respecting Consent to Treatment. Before you start, could you give us your names and what you do in the ministry? You will have roughly a half-hour for your presentation, so there will be time to ask questions. When you're ready, please.

**Mr Gilbert Sharpe:** Gilbert Sharpe, the legal director at the ministry.

**Ms Giuseppa Bentivegna:** Giuseppa Bentivegna, legal counsel with the ministry.

**Ms Jutta Auksi:** Jutta Auksi, senior policy consultant, legislation policy unit, Ministry of Health.

**Mr Sharpe:** Just before we get going, I'd like to observe that once again, unlike Citizenship and Health, Steve Fram came with no one but himself. Although this isn't estimates, perhaps you might look kindly on more resources for the AG at the appropriate time. He does a very commendable job on his own, mind you.

I know you have some material in your packages. What I thought we might do is take the reprinted bill and just run through it, highlight changes we feel are significant and, mindful of the time, try to get through it as quickly as we can to leave time for your questions.

Starting at the definition section, the first definition I think is significant is the one of "rights adviser" on page 3. We call it that; originally we talked about "advocate." The function is simply to impart information to individuals as to what opportunities are available to them when they're found to be incapable, and it's not a true advocate function in the sense it is under the Advocacy Act, so the term is changed to "rights adviser." It could be either a person under the Advocacy Act or someone in prescribed circumstances or a member of a prescribed category, which might permit us to designate by regulation different types of people in different settings to serve as rights advisers and not necessarily use the resources of the Advocacy Commission itself.

On page 4 the definition of treatment is altered somewhat to add an exclusion for prescribed things. You might recall during public hearings concerns raised about matters such as bathing a patient and whether or not that would constitute treatment. Clearly it wouldn't, and we didn't want people to feel exposed to liability, so we've permitted some exceptions to the concept of treatment by designation.

Also on page 4, we've made a slight adjustment to section 4, "A health practitioner who proposes a treatment...shall ensure that it is not administered unless"—recognizing of course that some treatments aren't necessarily done by the health practitioner; they may, for example, be carried out by a nurse. So it's a question of the



physician, say, ensuring that certain requirements in section 5 and following are adhered to.

In section 5 we've made a few minor adjustments to clause 5(2)(a) on informed consent. At the end of (a) and in (b) we've made some additions to recognize that health practitioners must also respond to requests made by patients about the treatment and alternative courses of treatment and so on, in addition to just imparting basic information.

On page 6, section 8 has been deleted. That was the age of consent provision, the 16 rebuttable, that so many people at committee seemed to be concerned about. We've taken it out entirely and we're relying on the common law which, of course, is simply a matter of when the young person is sufficiently capable to provide an informed consent, and it will vary with the complexity of the procedure that's being proposed and the maturity of the young person. It provides sufficient flexibility that we feel, with the other safeguards that are embraced in the bill, that it may in fact be more useful than having a rigid age, where physicians and others have to rebut presumptions and may not do so, which could of course result in barriers to health care for some young people and for certain types of services. So we've taken out any reference to age.

**Mr Sterling:** Could I ask a question? Why not codify the common law?

1650

**Mr Sharpe:** We have. The common law is reflected in the concept of capacity, and since the capacity test now applies to everyone, including youngsters, it's simply a matter of the practitioner deciding whether he or she is dealing with a capable person. As we see now, as we're getting into section 10, the rights advice, following a finding of incapacity, applies at the age of 12 and over. We'll see in a bit that even persons under 12 have access to the review board, but it's just that they're not rebutting anything. It's simply a matter of the practitioner deciding if he or she is dealing with a capable person.

Getting into section 10, you will recall that originally section 10 required an advocate's visit every time the person was found incapable, no matter where he or she was and in whatever kind of health care setting. Many concerns were raised about that, so we've changed that section probably most significantly of any provisions of the bill. What we now have in subsection 10(1), if a practitioner finds a person 12 and older to be incapable, to be incompetent, you tell the person that. I think it's only common sense to tell someone that he or she is not capable and that someone else is going to decide things for him or her.

In subsection 10(2) and following, these are now the provisions that will trigger rights advice. We're retaining, in a psychiatric facility, the concept of telling people who have been found incompetent that they have the ability to challenge that finding to the board and that they're entitled to meet with a rights adviser and to make an application to the board.

In subsection 10(3), in settings outside a psychiatric facility or designated or prescribed facility, the practitioner is only required to tell persons 12 and older of the right to go to a review board. If it's a controlled act within the

meaning of the Regulated Health Professions Act, that is not an excluded controlled act.

The notion here is that the controlled acts tend to be the more serious intrusions in care that carry with them risks that would normally require an informed consent, so if that type of procedure is contemplated in any health care setting, then it carries with it a requirement that rights advice be imparted to the individual patient. It doesn't necessarily mean you have to have a rights adviser visit them. The concept is that if the patients are then being told they could have a rights adviser and they indicate they would want that visit, then treatment would be delayed to obtain it; or if they object to the treatment, then a rights adviser could be brought in at that point, but it's not a requirement that every time a patient is found incapable with respect to any health care treatment there must be a visit. That's basically the concept in section 10.

Subsection 10(4) then gets into the obligations to notify of the rights advisers and so on. The rest of the provisions deal with the mechanisms for visiting and so on, and exclusions similar to what we had in the old section 10.

Subsection 10(13), on page 8, is the provision that says nothing in this section affects the right of a person of any age to go to the board or give or refuse consent with respect to a treatment. So although we've chosen age 12 as the point at which rights advice is triggered, those under 12 have the same right to challenge the decision that they are not capable with respect to a particular treatment.

Sections 13 and 14 on page 9, we've streamlined. There are criticisms and concerns that it's hard to understand so, as you can see, in section 13 we have simply said the obvious, that a person, while capable, can express wishes. They can be in a power of attorney, a prescribed form, another form, orally or in any other manner. Basically, if you have desires about how you want to be cared for in terms of health care treatment, you can express those in a number of ways. Later wishes, expressed while capable, prevail over earlier wishes, which is a streamlining and simplification of what we had.

Subsection 14(1) also has been streamlined. The person who's giving the substitute consent acts on the basis of known wishes, or if you don't know of any wishes expressed while capable, then best interests. The rest remains pretty much the same as to what "best interests" means.

Page 10, section 15: Concerns were raised during the hearings by some of the research community about research. We segregated out research from sterilization and organ donation so, as you can see, it has its own little section now dealing with the notion that nothing in this act is affecting whatever the common-law rights might be in terms of research. Professor Weissstub, as you know, has been asked to study the issue of research with incompetent populations, and we're hoping to receive his report in the fall.

Page 11, subsection 16(3.1): I believe Steve Fram talked a bit about the lowering threshold of capacity in executing powers of attorney. This section indicates that if the person comes into hospital, say, and has been assessed as incapable by a health care professional, after that finding was made for the purpose of treatment and our mechanisms of substitute decision-making would come in, at that



point the person cannot execute a power of attorney. They're incapable of understanding the treatment so as to give an informed consent. They've been found so. They have certain rights of review to the board we've discussed before, but they cannot at that stage execute a power of attorney appointing someone else and essentially nullifying our list of prioritizations. If they're going to get into that, they have to do it in advance through a power of attorney or otherwise.

Page 13, section 19: This is the admission to hospital notion, that the substitute who is consenting on behalf of an incapable person to the treatment can consent to the admission to a hospital or psychiatric facility or another type of health facility that's prescribed for the purpose of getting him or her that treatment.

Subsection (2) deals with the objecting individual. The original draft of section 19 said that if the person's objecting to admission for physical care, there had to be a guardian and then if it were for psychiatric care, the guardian would have to have special authorization to admit him to a facility. After much discussion with a number of individuals and listening to the people who presented here, we've dropped the requirement for a guardian for admission of the objecting person for physical care, but we've retained the notion that you need a guardian for psychiatric admissions, although the guardian doesn't necessarily have to have special authorization.

However, we've added in section 29.1 a status review. We've had this for years in the Mental Health Act for so-called informal patients, or kids. This allows someone who is brought into hospital on the authorization of a substitute to ask the review board to consider a number of conditions to decide whether or not he is in the most appropriate setting. We'll come to those in a few minutes, but we've added that as a safeguard while allowing the substitute to have the authority to get someone in for physical care even if he's objecting.

Section 22 gets into the emergency treatment area. As you know, there have been many concerns raised during the hearings on the way in which this was put together originally and questions about whether it would slow down care in emergencies. We have made some changes based on much of that input. For example, we removed the provision that required that the likely harm would happen within 12 hours, we deleted the 72-hour requirement—you can only give the treatment in an emergency for up to 72 hours—and we added in 22(1)(b) the notion of severe suffering, someone who is in severe pain, in addition to the concept of at risk of suffering serious bodily harm as authorizing limited treatment where the person is incapable and there's no substitute readily available to provide a consent.

Subsection 22(3.1) responds to the concern of providers that the way the section was drafted they didn't feel they could conduct a preliminary examination to determine whether emergency conditions truly existed, that it seemed to be a cart and horse problem, so as you can see there, we've provided the health practitioner with the authority to conduct an examination. In the last few weeks we've talked to a number of providers. The College of Physicians and Surgeons would like to see "examination" defined to

include basic diagnostic investigatory procedures. They're concerned that a simple reading of this may be that all you can do is, say, put a stethoscope to someone's chest, that you can't do any more.

I think that's certainly worth looking at as we get into clause-by-clause, because it's clear we've created this provision to enable some basic diagnosis to determine whether there's a true emergency. If the profession's telling us that we're still a bit ambiguous, then my own view would be to try to define the term in a way that gives some clarity to it. That's just something to think about later on.

1700

**Mr Winninger:** I wonder if that would extend to a blood test, or is that the kind of clarity you're seeking?

**Mr Sharpe:** I think we should talk about that. There may be circumstances where a blood test or a spinal tap, for example, to determine whether there's infection in the spinal column might diagnose meningitis or some serious ailment with an unconscious individual and no one is there to give consent. We're told that may be necessary, although it's quite intrusive.

Just to finish off, subsection 22(9): I wanted to point out that this says, "The authority to administer treatment... includes authority to have the person admitted to a hospital for the purpose of treatment, other than treatment of a mental disorder, as defined in the Mental Health Act."

This is different. We did allow emergency admission to psychiatric facilities as well under the original draft. The concern here was that the committal criterion safeguards of the Mental Health Act might be circumvented in so-called psychiatric emergencies. That was not intended by the draft, so what this means is there is no emergency admission for psychiatric treatment. Remember, in section 19 we said that where there's a substitute, he or she can sign the person in for psychiatric as well as physical care. In a physical emergency, 22(9) would apply and the power to admit is there without the need to have a substitute. However, for psychiatric emergencies, one would have to go through the Mental Health Act procedure. Many of you know the very carefully worked out safeguards that have been developed there over the years.

Section 23.1 is new. Concerns have been raised about someone who is a remote next of kin refusing lifesaving treatment and whether he should have that power, particularly where it may be fairly clear to the provider the person is not acting in his best interests or necessarily reflecting his wishes. There's no living will, power of attorney, advance directive or anything of that sort; there's no card in his wallet. This section would permit the health practitioner to provide the treatment except where the refusal is given by someone in the first three categories. That's the guardian, the person acting under a validated or an unvalidated power of attorney or someone appointed by the review board as the substitute. If any of those people say no, it's no.

But then we get into this list of people we have, next of kin. If someone there says no, if the health practitioner is of the opinion the incapable person is suffering severe pain or at risk of suffering serious bodily harm—again, the emergency criteria. If treatment isn't administered properly and



there are reasonable grounds to believe the substitute hasn't complied with section 14, which is accurately reflecting the wishes or best interests, then the emergency lifesaving treatment can be given. Again, that's something that perhaps the committee will want to discuss further in clause-by-clause, but it was considered an important balance.

I think when I first talked to you here in December we went through the notion that it's not, in my view, clear in law now whether a substitute could prevent lifesaving treatment if a person were brought into emergency unconscious and dying. Could the substitute say no and prevent treatment where there's nothing to indicate that the person would not have wanted the treatment? We're not talking about Jehovah's Witnesses with cards and so on.

It's a difficult issue, and I think most providers today in those circumstances would give the treatment necessary to save the life. This is codifying the situation unless there are powers of attorney, living wills or substitutes appointed by the court or the individual. As Steve indicated, we've augmented the criteria under which people can apply to the board and we've allowed the substitute to go into issues of whether the person was capable when his or her wishes were expressed.

Subsection 29(1) on page 19 is the matter I referred to earlier about providing a status review for people who were signed into hospital by a substitute and then they decide they don't want to be there. This sets up a process for them to go to the board. You can see there's a series of criteria in paragraph 29(1)4 that the board could review to decide whether that placement is the most appropriate one, and the board in fact can order that they be discharged from hospital.

We've added some procedural provisions. Section 40.1, on page 24, allows the board chair to make rules of procedure, and this is common for other tribunals as well. Section 45, on page 26, which finishes off what we started discussing on the definitions of rights advisers and so on, allows us to prescribe categories and circumstances of rights advisers. Clause 45(a.2) deals with prescribing things that don't constitute treatment, like bathing a patient, and prescribing health facilities and controlled acts are dealt with later on. In section 47 the coming-into-force provision of the bill was altered from the time the Advocacy Act is proclaimed to proclamation, which of course is the norm for most bills.

Would you like me to review the changes to Bill 110 as well or have questions on Bill 109 before we do that?

**The Chair:** I think we probably have the time that we could proceed with Bill 110 at the same time.

**Mr Sharpe:** You have some material in front of you describing those changes. Very briefly, the major change that was not in Bill 110 originally is to the Child and Family Services Act. As most of you may be aware, there are provisions in that statute dealing with secure care for young people. Some of those provisions deal with treatment, and it was necessary to make alterations to the Child and Family Services Act in order to make it consistent with ours.

As an example, on page 3 of Bill 110 there is an amendment to subsection 40(9) of the Child and Family Services Act. A child protection worker who has apprehended a child may, if the child is under 12, require a medical exam of the child, and for that purpose, the Consent to Treatment Act is cut out. For a child who is 12 or older and is not competent, then that child protection worker is deemed to have authority under the Consent to Treatment Act to provide the consent necessary for the examination. This is typically a situation where, say, a young woman suspected of having been abused by her father is brought to the hospital emergency after apprehension and an examination is necessary, perhaps, in order to gather the evidence necessary. The young person, if capable, should, consistent with the rules in the consent act of the common law being codified on age, be able to say no if she doesn't want that done. However, if they're incapable, then we're allowing the child protection worker to stand in the shoes of the parent and authorize the examination.

The changes to the bill in the next few pages, for example on page 5 at the bottom in subsection 132(1), also deal with age. The Child and Family Services Act originally had age 16 for many purposes, and what we're doing is creating the flexibility of the common law in most cases that we've put into Bill 109. Those are the major changes to the bill.

There are some minor changes we've made to the Mental Health Act, dealing with access to records and other matters, but I think in the interests of time I've highlighted the major changes from our perspective, and I'd be happy to take questions.

1710

**Mrs Sullivan:** We have been quite impressed with the number of changes and the approach that was taken on this bill. I think that in many areas a lot of the very serious concerns of health care providers were met. There are a couple of areas that are new to the bill that I'd be interested in hearing more from you on. One of them is the ancillary treatment section, 19.1. Would you see the consent provision in that section applying to situations where surgery might be alternative to the original surgery that was envisaged in the consent or where surgery might be extended from what was originally there? Does treatment that's necessary and ancillary to the treatment include those scenarios?

**Mr Sharpe:** No. This is in response to concerns, as an example, raised by OMA and the college. If a consent were obtained, say, to surgery and then as a result of the preparation for surgery injections were required, blood drawn, all kinds of pre-op medication given, the notion of implied consent to those other things, which is normally taken to be the case under the common law, might not pertain because in this act we're talking about being very specific: getting consents to every act of treatment. They wanted it to be clear that when we provide for consent that consent can embrace things like pre-op workups for surgery that are necessarily ancillary to the surgery itself, to which the patient has consented. But during surgery, where it then becomes necessary to go on and do something else



that may be quite different or an extension, in my view that would require a separate consent.

If one's doing exploratory surgery for cancer, for example, the consent forms would normally take into account the fact that other surgeries may be necessary depending on what the surgeon finds, because most patients would consider it unreasonable to be awakened, have a discussion and have to be put under again. The provision we've drafted certainly is not intended to give *carte blanche* authority to surgeons to go off and do whatever else might be considered appropriate in their minds while the patient's under anaesthetic. As I say, it was just to cover other forms of treatment given during the preparation for the major treatment to which the patient has consented.

**Mrs Sullivan:** One of the examples we had before the committee came from AIDS Action Now relating to diagnostic tests that might occur during the course of treatment to lead to the next phase of treatment. Would you see a second consent necessary for those tests, or would they be part of the course of treatment and considered ancillary to the original treatment?

**Mr Sharpe:** We've defined "treatment" in the amendments, as you know, to include a course of treatment. That was one of the concerns raised. I really imagine it would depend on the medical definition of what is embraced in the proposed care that's offered to a patient. If we were to go into hospital and be told that in order to properly diagnose our problem a series of tests had to be undertaken, depending on whether those specific tests carried with them risks—an intravenous pyelogram has risks and there have been deaths—most hospitals have gone to individual consents for those tests. Certainly in my view the consent to the overall approach to the care would not have necessarily embraced that IVP that's about to be proposed and conducted.

My experience is that much that's done in hospitals is viewed by counsel from the perspective of risks that the hospital and doctors are exposed to. So if it's viewed as important that patients consent specifically to certain types of intrusive tests, then there is a very careful delineation of those tests and separate consents are obtained.

Again, the notion of ancillary care and ancillary treatment, from our perspective, probably could embrace a lot of those tests if the purpose for the admission was to diagnose something and it was difficult to get a handle on what the problem is. So one could go in and consent in a general way to a number of investigatory treatments and diagnostic techniques being used that would carry with them ancillary dimensions. But generally speaking, the profession moved away from blanket consents some time ago. At one time you'd go into hospital and sign a general consent to anything that was required. Those are very rare. I think the reason for them is clear: At common law they really afford no protection.

**Mrs Sullivan:** Certainly one of the areas I'll be following up on is whether women feel that's the case in terms of their treatment. Too frequently we know of tubal ligations that too readily lead to removal of the ovaries or

further action. Perhaps before we go into the final consideration of this bill we'd like to look at some of those areas.

You moved from instructions to wishes. Bill 108 continues instructions. Could you address the question of why, and is there still compatibility?

**Mr Sharpe:** Our view was again based on discussions with a number of people, that instructions are something much more formal. A client instructs a lawyer to prepare a will in a certain way. I think much of Bill 108 carries with it the notion of formality: formal court applications and powers of attorney that have been validated, that are formal documents that have been completed in a certain way and witnessed and so on and that contain instructions.

We've indicated that if there is that type of power of attorney we would consider that to govern and take priority and guide the substitute over other things. But our view is that from a health care perspective, speaking in a more colloquial term, it's patients expressing desires or wishes as to how they might want to be treated.

Those wishes would embrace instructions that are formally set out by a Jehovah's Witness or someone with the Dying With Dignity organization or others, but they might also be expressed just in a statement of one spouse to another. We wanted in our bill to stay away from the formalized concepts of expressing your wishes for health care purposes. If the wishes are known, no matter how expressed, they are to be given priority. That's the approach we've taken.

**Mr Sterling:** Can I just ask a question? What is the obligation of the health care provider to follow the wish under your legislation? There's some common law already established in Ontario that there is an obligation to follow the written wish of a patient. Under section 13 you leave it pretty open as to—

**Mr Sharpe:** In section 4, what we've said is that the health practitioner who proposes the treatment cannot administer it unless he has a consent. If the person's incapable, the consent has to come from the substitute. Then in paragraph 14(1) the substitute is bound by the wishes, if known. So when you put them together—you have the prohibition in section 4, the doctor can't proceed without a consent, the substitute must provide the consent only in line with the wishes of the person he is representing—I think therein lies the obligation.

**Mr Sterling:** Under section 13, any living wills that have been made in the past would, of course, "live on."

**Mr Sharpe:** The thing we wrestled with in section 13—and again I think, when the time comes, it bears some discussion—is that if someone has made out a living will or a power of attorney and later on is not in a position to formally revoke it but wants to and tells someone close to him he has changed his mind and we've set a structure up that says to undo what he has done formally it must be done through some formalized mechanism, it may prevent someone from changing his mind when now faced with the crisis he anticipated but didn't really appreciate when he was well.

So in subsection 13(2) we said that wishes may be expressed in a number of ways: in a power of attorney, in a



form we could prescribe for advance directives and any other written form, orally or in another other manner. To say, as we did in the old section, that the power of attorney or the living will takes priority isn't really that meaningful when you go on to say as we did, "However, if you know there are prior wishes or more recent wishes that indicate the person has changed his mind, then those govern."

So in fact all we're saying here is that wishes govern, no matter how expressed, and must be listened to. The more recent wishes are the ones that take priority, no matter how expressed. You can say, "Yes, but that's subject to abuse," because when the patient is incompetent, the family could say, "Notwithstanding that power of attorney, they told us last week that they're frightened and they want to be kept going on the life support." The way this is drafted the physicians would then be in a position of having to listen to that. But to not do that—do we want to put an obligation on people to have to undo what they did in a formal way? It's a difficult issue. This makes it easier to override a power of attorney by the family, but to not do this creates problems as well.

1720

**Mr Sterling:** Just refining there, and I don't know whether you dodged it or didn't understand—

**Mr Sharpe:** I probably dodged it.

**Mr Sterling:** If you have a living will today and this legislation comes into effect tomorrow, it doesn't negate what you did before the legislation.

**Mr Sharpe:** No, it doesn't. It's an expression of wishes and it would be valid.

**Mr Sterling:** Okay. I was asking that on behalf of Dying with Dignity.

**Mrs Sullivan:** I wanted to pursue the line of questioning I was raising relating to Bill 108 and the assessor. Under this bill the health practitioner is the assessor.

**Mr Sharpe:** Yes.

**Mrs Sullivan:** There perhaps could be other people who are assessors and who may have reached a conclusion about the capacity of the person to deal with certain issues, including health and personal care. Who would have the override?

**Mr Sharpe:** You guys can jump in if you think I'm wrong, and I may well be, but the way I see this operating would be that if there is a guardian appointed by the court, that decision that's been made in that capacity would govern, and when the person came in for health care the guardian would make the decision. There wouldn't be any need to have the health practitioner decide whether or not the person was at this time incapable.

A power of attorney that's been executed and that has been validated, through assessments of incapacity may speak generally of personal care decision-making but still may not be specifically related to the actual health care decision that is under consideration. I would expect that in those circumstances the physician might still look at the person, make his own assessment and may decide he is capable. If they decide they're incapable, then they would of course go to the person appointed under the power of

attorney for personal care. But if they decide they are capable, then they would let them make their own decision. If I'm wrong on that you can tell me, but I would hope that it's not a situation where you would have to take the power of attorney as a given indication that they're incapable and then have to somehow reverse that process before they would have autonomy to make their own health care decisions.

**Ms Auksi:** I'd just add a little bit. I think the expectation is that if a power of attorney has been validated, it would most likely include an assessment for purposes of health care decisions, and in that case the health practitioner would not be making a separate assessment of capacity for each treatment decision. However, by leaving it that the health practitioner can, it means that unvalidated powers of attorney can still honour who the person is who's been named, and all that would be required is a finding of incapacity to have the attorney be able to make the decision. So you could have the person simply arriving for treatment without a formal assessment being made, but for that decision he wouldn't have to go through the process for the broader incapacity finding.

**Mrs Sullivan:** In clause-by-clause we may want to talk about that a little more just for clarification.

**Mr Sharpe:** I would just point out that section 12 does deal with it and would seem to give priority to both the guardian and the person appointed under the power of attorney for personal care that's been validated. But there may be an issue as to whether or not that should be altered.

**Mrs Sullivan:** If the person for certain treatments could be capable, even with all this other stuff around.

**Mr Sharpe:** That's right.

**Mrs Sullivan:** Are midwives covered?

**Mr Sharpe:** Midwives are covered under the Regulated Health Professions Act, so they will be, yes.

**Mrs Sullivan:** So they are in the list.

**Mr Sharpe:** Yes.

**Mr Sterling:** I want to say, and I did say it to Mr Fram, that I'm generally pleased with the changes to Bills 108 and 109, but because they are complicated bills I'd also really like to hear some of the people who are involved in the bottom line of these things and how they would react to them.

What is the net result of Bill 109 now with regard to someone who is under 12 years of age?

**Mr Sharpe:** And wants to make his or her own decision on health care?

**Mr Sterling:** You remember we had the dentist here who said Johnny comes in, Mom says, "Get in the chair," and he says, "No way."

**Mr Sharpe:** I think the parents can coerce Johnny at will now without fear of having triggered an advocate's visit. The obligation to provide rights advice is 12 and up. Even if Johnny is seen as objecting to the dental care in that situation, unless Johnny knows that he has a right to go to the review board and by triggering the process can delay the treatment, he would probably be strong-armed



into the chair. But his right is still there to go to the board; he probably just won't know about it.

**Mr Sterling:** I don't have any further questions. You had extensive consultations with some of the people who were here. I don't know whether I should be asking Paul this question or not. Are there any who are still concerned about the act, or are most of them placated by the changes?

**Mr Paul Wessinger (Simcoe Centre):** I have not had any particular input yet from the groups, but I understand that generally it's felt there's a good balance with respect to the rights of the individual, the consumer, and the rights of the providers with these amendments. That's generally the perception I have of the bill, that we've achieved a good balance here with these amendments.

**Mr Mark Morrow (Wentworth East):** Before I ask my question, I want to thank you for taking the time to come and explain the amendments to Bill 109.

During our public hearings we heard a lot of concerns that family members would be unable to make timely treatment decisions for their mentally incapable relatives because of health practitioners' concerns as to the search for the highest-ranked relative. Do these amendments address those concerns?

**Mr Sharpe:** I should have mentioned this with section 16 when we were going through this; I guess I jumped over it. Page 11, subsection 16(5.1): The concept is that if someone in the list of substitute decision-makers—family members, next of kin—happens to have taken the person into care and wishes to make the decision for him to have the treatment rather than delaying and searching for someone higher up the list, what we say here is that the person who is present may give or refuse consent unless he has reason to believe someone higher up the list is available or that someone higher up the list would want to make the decision or that the person himself would object to his making it. Those types of safeguards are in, but basically we've provided a mechanism for whoever happens to be present with the incompetent person to give consent to the treatment, even if he's not the highest-ranking individual.

**Mr Morrow:** So the concerns have been addressed.

**Mr Sharpe:** We hope this does it. It's always a balance. We've put the provision in, but then we've put some obligations on the substitute to ensure he doesn't know of anyone higher up that he should be searching for to bring down quickly to the hospital. We would think this type of change and some of the changes to the emergency sections would address those types of concerns. Certainly the discussions we've had so far with the limited number of groups have supported that.

**Mr Morrow:** That's all I have, Mr Chair.

**Mrs Sullivan:** I have no further questions of Mr Sharpe or the other representatives from the Ministry of Health, but I do want to discuss an issue for the committee in relation to the agenda.

**The Chair:** Okay, we'll take that up immediately following this. Seeing no further questions or comments, Mr Sharpe, Ms Bentivegna and Ms Auksi, on behalf of the

committee I would like to thank you for taking the time to give your briefing to the committee today.

1730

**Mrs Sullivan:** While this has been a long process and there have been substantial amendments put forward by the government in relation to these bills, I think the number of the amendments and the complexity of the interrelations has been problematical not only for members of the committee but for the groups and organizations and individuals who have been interested in pursuing this legislation and who have appeared before the committee. We had a formal request from a coalition of organizations from Alzheimer's, College of Nurses, College of Physicians and Surgeons, Friends of Schizophrenics, Ontario Hospital Association, Ontario Medical Association and the Ontario Nursing Home Association. I have had subsequent calls from other groups and organizations, including the National Association of Women and the Law and the Ontario Nurses' Association, saying they would appreciate time to appear before the committee to address some further issues.

However, in order to do that, they need additional time to study the impact of these amendments. We had some preliminary discussion. The issue was going to be dealt with in meetings of the House leaders. I think it's now time for us to provide some indication of our views on when people could come before the committee, what the length of an additional public hearing process would be and then when clause-by-clause would commence.

**The Chair:** Discussion? Mr Sterling.

**Mr Sterling:** I don't know if the clerk or researcher can help us. Have we any indication at all from various witnesses we've had before us if they want or are ready to come back to the committee with regard to the amended bills?

**Clerk of the Committee (Ms Lisa Freedman):** I handed out to the committee yesterday the list of anybody who had faxed or written me.

**Mr Sterling:** I didn't see that. Are any of them ready to come and talk to the committee at this time? Have you any indication from anyone?

**Clerk of the Committee:** I think a lot of the people I spoke to on the phone are furiously preparing. That would be fairly accurate.

**Mr Sterling:** I understand, at least from our House leader, that the House leaders have made a tentative arrangement that we would try to start our public hearings as soon as we could during the month of June, and also have provided for two weeks during the summer to continue those hearings. That's what our House leader indicated to me this morning. Until the Chair has an opportunity to talk to his House leader, I guess it's pretty hard to get to the next step.

**Mr Winner:** I respectfully ask, Mr Chair, whether this question can't be deferred until next Monday and in the meantime, if it's necessary, have a subcommittee meeting, because I understand the House leaders are meeting to discuss this very issue of scheduling tomorrow and also on Thursday. Until we hear their collective wisdom on the issue, it might be premature to start setting down any hard and fast dates.



**The Chair:** Possibly we could have a subcommittee meeting on Thursday afternoon, after the House leaders have met.

**Mr Sterling:** The information I'm going to need is how quickly these people can respond. If the clerk can help in any way, I'd appreciate that knowledge on Thursday.

**Clerk of the Committee:** I can add that I've told the people who have called me that given how things historically tend to work around here, if there are public hearings—which decision has not been made—they could start as early as next Monday, which could be the next sitting of the committee. So people are aware that, should a decision be made, this committee sits on Monday and Tuesday and the hearings may just be the next natural step.

**Mrs Sullivan:** I want to bring to the attention of the committee, though, that a specific request which came from the organizations I earlier read said this specifically: "While the amendments have resulted in what appear to be significant improvements in some areas, there are also issues

that continue to be of serious concern as well as some new provisions that require consideration. To that end, we request that sufficient time be given to permit thoughtful analysis of the new legislation and to assess its impact on those persons whom it is intended to help."

Certainly one of the organizations, the Ontario Medical Association, has indicated it wants to speak further with its own organization about some of the impact of the bills. The organizations listed here have indicated that they will not be ready to come back next Monday.

**Mr Sterling:** I think Mr Winninger's suggestion that we wait till next Monday to deal with it is probably best. We'll have a little more knowledge in order to make our plans.

**The Chair:** If it's the pleasure of the committee, we'll defer this until next Monday. Seeing no further business before this committee, this committee stands adjourned until next Monday at 3:30.

The committee adjourned at 1736.







## CONTENTS

Tuesday 26 May 1992

<b>Advocacy Act, 1992, and companion legislation</b> . . . . .	J-21
Ministry of the Attorney General . . . . .	J-21
Steve Fram, legal counsel	
Ministry of Health . . . . .	J-28
Gilbert Sharpe, legal director	
Giuseppa Bentivegna, legal counsel	
Juta Auksi, senior policy consultant, legislation policy unit	

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- \*Sullivan, Barbara (Halton Centre L) for Mr Mahoney

\*In attendance / présents

#### **Also taking part / Autres participants et participantes:**

- Sterling, Norman W. (Carleton PC)
- Cunningham, Dianne (London North/-Nord PC)

**Clerk / Greffière:** Freedman, Lisa

#### **Staff / Personnel:**

- Swift, Susan, research officer, Legislative Research Service
- Beecroft, Doug, legislative counsel



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## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Monday 15 June 1992

### Standing committee on administration of justice

Advocacy Act, 1992,  
and companion legislation

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Lundi 15 juin 1992

### Comité permanent de l'administration de la justice

Loi de 1992 sur l'intervention  
et les projets de loi  
qui l'accompagnent

Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
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### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

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### **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Monday 15 June 1992

The committee met at 1552 in room 151.

### ADVOCACY ACT, 1992, AND COMPANION LEGISLATION LOI DE 1992 SUR L'INTERVENTION ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervenants en faveur des personnes vulnérables; Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne; Bill 109, An Act respecting Consent to Treatment / Loi concernant le consentement au traitement; and Bill 110, An Act to amend certain Statutes of Ontario consequent upon the enactment of the Consent to Treatment Act, 1992 and the Substitute Decisions Act, 1992 / Loi modifiant certaines lois de l'Ontario par suite de l'adoption de la Loi de 1992 sur le consentement au traitement et de la Loi de 1992 sur la prise de décisions au nom d'autrui.

**The Chair (Mr Mike Cooper):** I call this meeting of the standing committee on the administration of justice to order. Today we will be proceeding with the second round of public hearings on advocacy bills: Bill 74, the Advocacy Act, 1992; Bill 108, the Substitute Decisions Act, 1992; Bill 109, the Consent to Treatment Act, 1992, and Bill 110, the Consent and Capacity Statute Law Amendment Act, 1992.

First we have a couple of announcements. The House leaders have agreed to let us meet starting at 3:30 over the next two weeks, whether we're out of routine proceedings or not, because of the number of presenters we have coming in to make presentations again.

Second, there was a question from Mr Sterling, I believe, that was asked quite a while ago of the Ministry of Citizenship. We now have the answers to that and they will be handed out to the committee members.

Also, the research we've asked Susan Swift to do for us is not complete today. Hopefully it will be complete tomorrow, but the computer network has been down. I hope it will be fixed before tomorrow and we'll have that prepared for the members of the committee.

### ADVOCACY RESOURCE CENTRE FOR THE HANDICAPPED

**The Chair:** At this time I would like to call forward our first presenters, from the Advocacy Resource Centre for the Handicapped. Good afternoon. As soon as you're comfortable, could you please identify yourselves for the record and then proceed.

**Ms Carol McGregor:** My name is Carol McGregor. I am the president of the Advocacy Resource Centre for the Handicapped. With me is Carla McKague, the senior staff litigator, and David Baker, the executive director.

The Advocacy Research Centre for the Handicapped, more commonly known as ARCH, is a specialty legal aid clinic that was established 12 years ago to promote equality rights of people with disabilities. ARCH is comprised of 43 member organizations with a membership mainly of people with disabilities. One of the main criteria for joining ARCH must be that an organization supports the principle of self-advocacy for people with disabilities. This membership obviously supports the Advocacy Act, and that is why we are here today.

We believe there is no doubt between all three parties that this is not a partisan issue: From the Tories under Roy McMurtry who appointed Rosalie Abella to conduct a report, and who then appointed the Fram committee which established the first model on advocacy; under the Liberal government under Ian Scott, Father Sean O'Sullivan developed the Advocacy Act legislation; and in April 1991 the NDP government introduced the Advocacy Act legislation in Ontario. We are still waiting for this legislation.

We congratulate you, however, on the fact that all parties have finally come to an agreement to introduce the legislation in one month's time, following yet again another round of public hearings. We are happy with the amendments; we support the amendments. We hope they do clarify and make other opposition members understand some of the more technical aspects of the legislation. But for people with disabilities, this legislation is a necessity and it should be a right. We need to have this type of protection. We need to have legislation and we need to have it implemented immediately.

I'm going to ask David Baker to perhaps provide you with more of the technical background.

**Mr David Baker:** I'd like first to talk about one particular case in which ARCH was involved some years ago, which in many ways crystallized for us the issues that underlie this legislation.

The case involved a young man with cerebral palsy named Justin Clark. He had been institutionalized by his parents at the age of one and a half in the Rideau Regional Centre. He had not been in communication with his parents for a considerable period of time following admission to this facility. For a very long time people had assumed he was unable to reason, think and make decisions on his own behalf. Basically, his cerebral palsy was such that he was unable to speak and he was unable to communicate until such time as a new system of communication, known as Bliss symbolics, was developed. And so at the age of 15 or 16 for the first time he was able to communicate with the outside world.



If you looked at his clinical record you would see that people, in assessing his capacity, felt he was an imbecile, an idiot and unable to make any decisions whatsoever on his own behalf. This is the kind of person for whom we have, and should have as a society, a great deal of concern.

When he decided he wanted to leave the institution and live in the community with the support of his friends, who were former staff members of the facility, first the staff of the administration of the institution and then, at the suggestion of the administrator, the parents, raised the issue of Justin's mental competency to make that decision for himself.

Through the intervention of his friends, or I could use the term "his advocates," he was able to get in touch with the Advocacy Resource Centre for the Handicapped. We were concerned that we were being contacted by advocates who may not have been acting on his instructions or direction, and so before we were prepared to go down to meet with him we insisted on receiving communication from him directly. The communication arrived in due course. It was basically a handwritten message. Obviously the advocates had written it down, with a very rough scrawl at the bottom of the page which was his attempt at a signature.

When we went to communicate with him, initially we were told he was not capable of having a lawyer, even though he was over the age of 18 and no one had been appointed his guardian. We were turned away. Only after some persistence and intervention at the senior levels within the Ministry of Community and Social Services was it possible to communicate with him more directly.

1600

As an advocate, a legal advocate in this case, it was important to establish who was in control, providing direction. In my first meeting with the administrator, I asked that Justin be present. The administrator refused. He said it would be contrary to Justin's interests to be present in the meeting. I indicated that I could not carry on the communication without my client being present. I then went down the very long corridor to the ward where Justin was kept and told him this. Through a rather tortuous process involving the use of Bliss symbols he told me I had acted too precipitously and that in his judgement I should go back and be more compromising in my dealings with the administrator. At that point it was quite clear in my mind who was providing the instructions—who was the advocate and who was the client in that situation.

Through the court process, the relationship with the family was deeply problematic. The family obviously was acting in what they perceived as being in their son's best interests, and no one ever questioned that at any point. But clearly, in the end, when the court found that Justin was capable of making decisions for himself, there was a great collective sigh of relief and, I think, a sense in which justice had been done. The decision of the court was less attributable to any of the usual players in court—the judge, the lawyers and so on—than the testimony of Justin himself. Clearly, too, once everyone had heard what he had to say on his own behalf, the message was quite clear.

But the point lingered for me for a long time afterwards that I honestly don't believe he and I together could have accomplished what was necessary to get that matter

into court. What was really essential was to have the assistance of the friends or advocates who assisted him in communicating with me initially, in supporting him and enabling him to persevere in the face of what for him must have been almost inestimable odds. In the end, as I say, people were pleased to see that justice was done and that Justin was free to make the decision he did and which eventually led to his leaving the institution and living in Ottawa, where he has lived since that time.

I mention that story at some length because I think it illustrates a number of the reasons we are here going through a second round of hearings on this issue. A lot of it has to do with the response of family members to the idea of an advocacy system. You've heard and will continue to hear, I believe, from several groups such as the Ontario Friends of Schizophrenics, perhaps the Alzheimer society, that this issue of an advocacy system is not a priority for them. I suggest that may be true in their particular cases, but there are many people in situations such as Justin Clark's who do not have family members actively involved in representing their interests or in supporting them to protect them from the kinds of abuse and neglect people can experience, despite a well-meaning health care system.

So if you hear from people saying the money could be better spent elsewhere, that may be true in their particular case because they are family members actively involved on behalf of their sons, daughters, spouses or parents, but the majority of people in schedule 1 and 2 facilities for developmentally handicapped people who have no family member active at all on their behalf and who are referred to as citizens of the world have no advocate. For them, the issue of having an advocacy system is an extremely high priority.

That is why the number one priority for the Advocacy Resource Centre for the Handicapped since 1981 has been the issue of the establishment of an independent, consumer-controlled advocacy system, the only issue to which we have asked member organizations seeking to become involved with ARCH to subscribe.

We feel the amendments to the legislation have gone a long way in addressing the concerns that have been raised by family members. If I may, I would refer you to section 15.2, which can be found on page 10 of Bill 74. This section, which is a new section, asks that an advocate who is providing advocacy services to a vulnerable person "shall, if feasible,

"(a) consult with the vulnerable person to ascertain whether there are family members or friends who may be willing and able to provide assistance to the vulnerable person; and

"(b) if the vulnerable person agrees or is incapable of instructing an advocate, assist family members and friends in their efforts to provide assistance to the vulnerable person."

The point here, to many of us, was self-evident from the beginning. If there is an active, supportive, helpful family, it's quite likely that individual is not going to require the services of an advocate.

I would go further. Whatever resources are available to whatever government in such a prosperous province as this, we are still never going to have the resources necessary to provide advocates to people who don't need them.



As I say, there are thousands and thousands of people just in schedule 1 and 2 facilities who have no family member present. To us, section 15.2 merely expresses what was self-evident and inevitable from the beginning. However, if it serves to calm concerns on the part of organizations of family members, that's fine.

Section 10 is another new section. This is on page 7 of the bill. Section 10 requires that the minister establish an advisory committee composed of family members, non-professional persons and health and social services practitioners who provide services to vulnerable persons. Again, this would appear to us to be a natural support to an advocacy system and one we would have anticipated seeing. Nevertheless, if people feel this is useful, then we certainly subscribe to the addition of this section imposing an obligation on the minister to assist in the establishment of such a committee to assist the commission in its work. It's an appropriate role for family members and professionals to play within an advocacy system.

However, there is a section which was not changed and which is ARCH's first and foremost concern with respect to this legislation. That's subsection 15(2) on page 10. This is a section that in essence states that in the establishment of the Advocacy Commission it is not necessary that organizations representing persons with autism, Alzheimer's or traumatic head injury be consumer organizations, as is required for all other categories under the legislation.

1610

For us this is clearly the most objectionable for a number of reasons. First, it is totally inconsistent with the purpose of an advocacy bill to assume that any group of people who are going to be served by advocates are incapable of having their own organizations or their own voice. It is totally inconsistent with that. It is entirely consistent to do so in circumstances where we're talking about substitute decision-making or substitute consents in health legislation, but it's inconsistent when we're talking about people who are being supported in speaking for themselves to presume that they are incapable of establishing such organizations.

Second, it will prevent the establishment of new or further organizations of people with autism, Alzheimer's syndrome or traumatic head injury. Why? Because the history of these kinds of organizations, which is consistent across virtually all of these categories, goes as follows: The first to establish themselves and to establish a voice are the professional organizations; the second to establish themselves and to empower themselves through the establishment of an organization are the parents and family organizations; and the third and last to establish themselves, the organizations which have the greatest difficulty in finding resources and attracting the attention of the public, the press, the media and so on, are organizations of disabled people themselves.

By empowering parents' organizations to speak on behalf of people with autism, Alzheimer's syndrome or traumatic head injury, it effectively precludes the establishment of organizations which do not yet exist but which could have and would have existed if this section were not in the advocacy bill. It's analogous to saying that men must

speaking for women, that some other group can speak for you. This bill is about people speaking for themselves.

The third objection to this section is that it stifles the voice that should be given to the groups which do exist in these areas. We've made some inquiries and we have learned that across the province there are quite a number of support groups for people with head injuries. Indeed we've been in touch with a number of them over the years as they seek to establish themselves. These groups exist now.

I have heard and spoken to many people who have traumatic head injuries and I'm very impressed with their capacity to run an organization, so much so that the Alzheimer society has hired one of these people as its lobbyist on this legislation. I'm sure there is no connection but I make the point to establish that these are people who are very capable of speaking on behalf of themselves in many circumstances, and to say that their organizations will be overwhelmed by these other organizations of professionals and family members is most unfortunate.

In the case of Alzheimer's disease, this like the others is a relatively recently diagnosed disability. It is progressive. Its effects as we know are extremely serious in terms of one's capacity. However, we know that with early diagnosis and increasingly earlier diagnosis of Alzheimer's there are people who are aware of their circumstances and can make decisions for themselves. Indeed, that is why the sections in Bill 109 dealing with personal powers of attorney are so important to people with Alzheimer's. They know what is coming. They know what impact it will have on their lives and they are perfectly capable for as long as they are capable, of making those decisions for themselves. That is what they require of an advocacy system and that is why they should have a voice for themselves within an advocacy system.

At present we have a member of Parliament from New Brunswick who has learned he has Alzheimer's. He is capable not only of advocating on behalf of himself but he has concluded he is capable, at least until the next election, of advocating also on behalf of his constituents. This is the kind of person who is denied a voice by subsection 15(2).

Finally, in the case of autism we know, as is true for all the disabilities and all of these categories, that there is a range or spectrum of disability. But it is true that there are people with autism who are capable and do indeed organize themselves in support groups. I was informed this morning by the Autism Society Ontario that support groups of people with autism do exist. When discussing the potential of people with autism to speak for themselves—that is, whether they require an advocate as opposed to a guardian—in speaking to the Autism Society Canada executive director I was directed to the movie *Rain Man*. I don't know if you recall the movie *Rain Man* with Dustin Hoffman, but this is a movie about a person with autism. It was clear in that movie that while a person has a disability—it does have an impact—it does not prevent the person from establishing relationships, organizing and speaking on behalf of himself.

In fact, I was told by the Autism Society Canada representative that there has been a breakthrough as recently as last year in what they referred to as facilitated communication,



which is more severely disabled people with autism being found to be capable of speaking for themselves through a mechanism of facilitated communication. He stated that while most organizations representing people with autism at the present time are, in his words, "parent-driven," parents have been quite "shaken up" by the impact of facilitated communication and what it means to be able to speak for oneself.

We would say that for all these three reasons subsection 15(2) is unnecessary and in conflict with the purposes underlying Bill 74 and should be changed so as to require that in paragraph 6, as in all the other sections, only organizations of vulnerable persons should be permitted representation rights on the Advocacy Commission.

I would like to make four other quick points. First, the advocacy bill is part of a package. It could stand independently, perhaps, but Bills 108, 109 and 110 certainly cannot survive without the advocacy bill. It's not a compromise; it is a totally different approach to the issue of capacity which is attempted here. Instead of relying upon lawyers and due process under these bills, there is an attempt, through the intervention of an advocate, to counter-balance the power that non-vulnerable people have over vulnerable people. That's why it's essential to the survival, in our view, of these other pieces of legislation that there be a strong and adequately resourced advocacy system in place.

Second quick point: We're not aware of any other effective method of dealing with abuse of vulnerable people other than what is proposed here in the advocacy package. There are basically two methods of responding to the abuse of vulnerable persons. The first can be analogized to the child welfare system, where somebody steps in and intervenes, taking decision-making power away from the child. The second system represented by this advocacy model is one of strengthening people who are vulnerable in our society, not because of themselves but because of the problems that exist within our society. So by strengthening people through the provision of the support of an advocate it has been possible to come up with a different approach to the issue of abuse.

That's critically important because disabled people and seniors reject absolutely the analogy of their situation to that of a child. They reject absolutely the idea that they should be treated through a child welfare system. I point out as well, since at least the Toronto Star has seen fit to talk about resources, that even if we wanted a child welfare system, I would put it to you that there's no way on earth we could afford it.

1620

The issue of abuse is something ARCH has looked at carefully over a large number of years. We've been involved in many inquests into the deaths of people. We have been involved in an institutional outreach project which was coordinated by Patrick Worth, who is now co-chair of the Ontario Advocacy Coalition and past president of People First of Ontario, and who is present with us today. We've been involved in an abuse project and we are currently involved in yet another abuse program with the support of the Solicitor General of Ontario.

We are well aware of the issue of abuse. We've looked at it for a long time. We know what happens to people who are vulnerable in our health and social service systems. It is our conclusion that the only workable response to the issue of abuse is the establishment of an advocacy system.

The issue of whether or not the advocacy system is bureaucratic has been raised, again primarily by the Toronto Star. I think it is fair to question, as disabled people and seniors have questioned, the accuracy of a number of the points raised by the Toronto Star, but this one I think requires a special response.

It's not possible to do what is necessary to enable people who do not have family members there supporting them without having some resources, some access to information, some access to the individual. It's just not possible to do that. To pretend that we are addressing the issue of abuse without giving people those powers is pointless because it would only be a façade of action on behalf of that group.

There are many voluntary groups such as the Patients' Rights Association, Concerned Friends of Ontario Citizens in Care Facilities and so on which have struggled for a very long time without resources, without support of legislation of this kind, and have done an admirable job. But they are the strongest supporters of this legislation. They don't see their grass-roots identity being lost in a bureaucratic system. On the contrary, they see this breathing new life into their voluntary efforts on behalf of vulnerable people in this province, because the legislation clearly contemplates not that there will be 100, 150, 200 or however many staff-paid advocates out there, but it clearly contemplates that there will be a number of different models of advocacy provided which will in many cases involve extensive, if not almost exclusive, use of volunteers. This is something that, for whatever reason, has not been well understood by the critics of the legislation.

It's been our hope for many years that advocacy will grow from the communities that are there to support people, that the models used and supported by the Advocacy Commission will be as different as the ethnic population makeups of those communities and reflect the needs of those communities. We reject absolutely the idea that an advocacy commission which is accountable to vulnerable people, seniors and disabled people in this province would be bureaucratic.

I'm going to leave it there and pass it over to my colleague Carla McKague.

**Ms Carla McKague:** Given that our time here is quite limited, I want to address some of the issues in bills 108, 109 and 110. I'm going to address exactly three different types: One is an amendment we are very much in favour of, one is an amendment about which we have concerns and the third is an area that's remained unamended that we think is of major importance.

The first of these, which I'm just going to briefly address, is the addition to Bill 108 of section 47.1 in the present numbering, which gives quite a low level of competency for giving a power of attorney for personal care. This is an extraordinarily important section and very much has our support.

What this section says is that there may be people—and we know many people—who are not functioning at a



level that enables them to make their own decisions about personal care, medical care or perhaps about housing. However, they do know who to trust, they do know who loves them and who cares for them, so that someone who would not be able to make those decisions personally can choose the person who will do that for them. They don't have to undergo the often necessary but somewhat humiliating experience of guardianship. They don't have to be declared incompetent by a court. They can put that decision-making into the hands they choose: often a parent, a family member or a child, perhaps, in the case of someone with Alzheimer's. I recommend this section very strongly as a very important addition to this bill that will do a great deal to preserve autonomy and dignity.

The one we are very concerned about is an amendment to 109, the consent to treatment bill. Largely, I gather, as a result of an outcry by the medical profession that this was going to be far too cumbersome and bureaucratic and there was going to be enormous paperwork and enormous delays in getting treatment, some of which has foundation, section 10 of this act has been quite massively amended. While I think some of the concerns were founded, it's also our view that this section doesn't contain the answer. This answer significantly undercuts the protections that the Fram committee and every committee dealing with this has said are necessary for this kind of legislation. You can't come in and massively intrude on people's lives without safeguards, and the safeguards here, as David said before, are the advocates. This legislation can't stand without the advocates as safeguards, and in this particular area that safeguard has been drastically reduced.

What we have now is a whole bunch of different categories of people. First of all, if you're under 12 years old you have rights but nobody tells you about them. I find something a little strange in having rights of which no one is required to inform you. I leave that probably to people dealing more with children, who may want to address that in more detail.

Second, we have all these classifications of treatments: We have controlled acts, controlled acts except for prescribed controlled acts. You have to decide if something is or is not a controlled act, or is it a prescribed controlled act, which means we're going to pull it out in this legislation. We have to look at whether the treatment is in the hospital, a psychiatric hospital or another health facility, in the community. We have to look at a large number of things.

What it really comes down to is that if you're in a hospital getting something done to you that can only be done by a medical person and no one has decided to pull that particular something out of the compass of this act by regulation, then you get a rights adviser. In fact, the way it's written at the moment, it only happens to you if you are in a psychiatric hospital. This does say "prescribed health facility," but at the moment there are no prescribed health facilities. Psychiatric hospitals are the only places you would get rights advice. Anyplace else, they have to tell you you're incompetent and they have to tell you you've got a right to see a rights adviser if you want to. That's some help, but it's a significant cutback, particularly

with this wide-open door about what is going to be a prescribed controlled act.

#### 1630

We're not saying you should have to go through this rigmarole every time somebody wants to put on a Band-Aid. That's absurd. In fact, it seems to me that the act now differentiates between treatment, which includes putting on a Band-Aid, and controlled acts, which include things only doctors, nurses and other health professionals can do. Frankly, I don't care if we have any protections at all around putting on Band-Aids. I think we should be defining treatment in the same way as we define a controlled act, that a treatment is something only doctors, nurses and optometrists can do, and we should then be giving appropriate protections.

I would suggest there are compromise positions; we've discussed some with the ministry. One compromise position, for instance, might be to provide full rights advice in hospitals—including all hospitals, not just psychiatric facilities—and to provide the opportunity in the community. But I am very worried about this section. I'm very worried about this cutback in protections. Time just doesn't allow for any extensive discussion of other alternatives, but I would ask you to think about that very seriously.

The third area I want to address briefly is one that these amendments haven't touched and which I brought up when we were here before you a couple of months ago. That is the retention in this legislation of a section in the Mental Health Act that allows a single physician to sign a piece of paper and hand a psychiatric patient's money over to the public trustee.

This legislation, Bill 108, provides for what is called a statutory guardian of the estate. Other people get to choose to have the public trustee look after their money. Psychiatric patients do not. Psychiatric patients, as I said, on the opinion of one physician can immediately lose their money.

By the way, there are emergency provisions in this act for other people where there's a desperate immediate need to go in there and take over someone's money very quickly. Those emergency provisions would work just as well for inpatients in a psychiatric hospital as they would for anybody else. There's no reason not to use them.

What we have is something that is at its base discriminatory, but there's a second concern, and I'm not sure I addressed that last time. I want to address it now. That section of the Mental Health Act is, in my experience, the most abused section of any statute in this province. It was put in there for a specific reason originally. It was put in there because very often people reach the hospital in a psychiatric crisis, in a situation where it's very important to assume control of their finances; they may be indulging in wild spending or something of that sort.

That's not how the section generally gets used. It gets used as a shortcut for little old ladies with Alzheimer's. Instead of going off and doing it the right way with the legal safeguards, you simply pop them into a psychiatric hospital, get a doctor to sign a form and a notice of continuation and there you are. No fuss, no muss, no bother.

It's worse than that. It's routine practice to send a psychiatrist down when a little old lady's down on the surgical



floor and not even subject to the Mental Health Act: Fill out a form, she's incompetent, she doesn't have her money any more, and in fact she doesn't get any rights advice because it's not treated through the rights adviser program because she isn't a psychiatric patient.

The worst I've ever seen is taking someone who's not even in the hospital, who's never been in the hospital, arbitrarily declaring them to be an outpatient of the hospital and then making them financially incompetent when they've never even been there.

A section that is capable of this much abuse is a section that has to go. All the safeguards, all the protections in Bill 108 are going to be meaningless if they can be obviated by the simple mechanism of using or misusing this section in the Mental Health Act.

I don't believe I have anything else to say.

**The Chair:** Questions and comments.

**Mr Stephen Owens (Scarborough Centre):** Mr Baker, it's a pleasure to see you once again. I think your remarks were cogent and hit the nail on the head. My question to you is with respect to advocates and your comment that advocacy should not be bureaucratic and the commission should not be bureaucratic. My question is around the concern I am hearing currently with respect to advocates and the conflict they seem to feel between transfer payment agencies that pay their salary and then having to advocate on behalf of clients against the agency they are currently working for. How do you see this legislation changing that particular concern as well as keeping it the least bureaucratic as possible so it's an evolutionary process and growing with the different needs in society?

**Mr Baker:** As you're aware, the amendments make it clear that organizations that would be in a conflict-of-interest position, as are many of the transfer payment agencies currently supervising the services of adult protective service workers, cannot apply for and cannot be given funding by the Advocacy Commission. The provisions defining the class of organization specifically preclude funding of organizations that provide other services to vulnerable persons. This is something that has received the support of the Ontario Advocacy Coalition. ARCH is a member of that coalition and is supportive of that position.

**Mr Malkowski:** I was wondering if it would be useful to hear from the public trustee on the issue of statutory guardianship. He won't be coming unless he is formally invited by the committee. Could you suggest this?

**Ms McKague:** I certainly think it's always valuable to hear from the public trustee on these issues. He is the person who is going to be dealing with this later. On the specific issue I raised, I'm not sure how directly relevant it would be, because the public trustee of course is largely concerned with administering these estates once someone has filled out the paper. He's not obliged—and in fact I think he properly takes the view that it would be improper for him—to go behind the paper. He's not there to make findings of competency or incompetency but merely to administer once someone else has made those findings.

On the other hand, having dealt with a number of people put into the system through this mechanism, he may well

have a good deal more to say about it than I would think. I would suggest, in any case, given that Mr Paisley is the person who will be administering this system, that it would be valuable in a number of respects to have him before your committee.

**Mr Malkowski:** Perhaps I could ask a different question related to Bill 74, subsection 15(2). You were talking about a concern about including organizations of consumer groups—for example, head injured and autistic consumer groups. Those groups have not approached us. I'm wondering, have they approached you and made recommendations about changing the legislation?

**Mr Baker:** I think that's probably directed to me. The groups themselves are small and are basically self-help in their orientation. They are referred to as support groups. We have communicated with some of the head injury groups. I was on the task force for the Ontario Head Injury Association which received submissions from a number of these groups, so I'm familiar with them. I don't happen to have addresses and phone numbers for them. I think the mere fact these groups do exist, and no one denies they exist, suggests to me that there is no need for subsection 15(2) as it is currently worded. Perhaps we should be out doing our homework and tracking these groups down across the province. However, resources, time and other distractions have not permitted us to do that.

1640

Again, I think it is a question of principle. If you asked me 12 years ago if there were groups of developmentally handicapped people in this province, I would have had to say no. If you had asked me about psychiatric patients—again, the first groups of psychiatric patients I'm aware of really only started to come together about that time as well, in the late 1970s. There is a history and a progression to these things, as I tried to describe it, of moving from professional organization to family organization to self-help and eventually to advocacy organization, which has been the norm for all the other groups listed here.

The neurological conditions have basically come to light only recently. Traumatic head injury has only become an issue in the last 10 years because of advances in medical technology. These people didn't survive traffic accidents 10 or 15 years ago. It's that recent. Alzheimer's has only been separated out from senile dementia in recent years. Autism: Again, it has been relatively recently that there have been advances in this area. As recently as this past year, people it had previously been assumed were non-communicative, unable to speak for themselves, through the mechanism of facilitated communication are now being found to be capable of speaking for themselves. It is like the Justin Clark situation. Until Bliss symbols were developed, Justin was assumed to be incapable of making any decisions. He was unable to communicate.

To me, the assumption underlying subsection 15(2) is that these groups are somehow fundamentally different from other groups and I think that is absolutely wrong and inconsistent with why we have this here. If these people are incapable of speaking for themselves or organizing themselves, we should just say that people with autism,



Alzheimer's syndrome and traumatic head injury should not have an advocate. If you ask those organizations whether that is the way they feel about it—that is, parents, family-member organizations in these categories—I think you will be told, “No, absolutely, these people would benefit from the assistance of an advocate.” Why? Because they are capable of speaking for themselves with the assistance of an advocate. That's what this is all about. So the short answer is, “No,” but the longer answer is “So what?” Let's give these people the chance to come forward and the next time there are hearings on this issue, I'll bet you dollars to doughnuts they'll be here.

**Mr Alvin Curling (Scarborough North):** The ARCH group, as you know, has contributed tremendously to advocating for those who are most vulnerable. I want to commend you for your presentation and hope that, of course, it's progressing the way it's of benefit to all. As you were making your presentation, I noticed that both of you have some reservations about some of the amendments our government has put forward, and like anything else you can't have a perfect bill.

Your last comment, too, brought me to a point when you were asked about other groups not included yet and should they come forward and make their presentation. You said: “No, they have not yet done this. Maybe we should put this through quickly and then later on,” if I understand you correctly, “then the presentation or their case could be made, because then at least we have to get on with it.” I presume I'm hearing, then, that it is urgent that we should proceed as quickly as possible. On the other hand, if these things become law—one of the things I have discovered since I became a legislator is that as soon as a law becomes effective it is one hell of a thing to get it back off if it is wrong or even to amend it. We should be very careful about this. Do you feel the progress of this is too slow or is it extremely important that we go rather carefully to make sure that those who are not yet included be included?

**Mr Baker:** I think the view is that the process has been a lengthy one, as our president Carol McGregor has said. The history of government being called upon to deliver this kind of legislation goes back to 1981. It has involved action by the Progressive Conservative government, by the former Liberal government and now by the New Democratic Party government.

We're pleased to see the matter is progressing. We're pleased to see that it's progressing on a non-partisan basis with all parties attempting to improve the legislation to the extent that it is possible. We're pleased to see that everyone will have a say in that process and we're pleased to see that the end is in sight because it's time to actually do something after having laboured for 11 years trying to get this legislation through.

In terms of the particular issue which we are raising, subsection 15(2) of the advocacy bill, that was a matter which was raised in the first round of hearings and we were mystified to see that the one issue that we felt was of sufficient concern to be our overriding concern in relation to advocacy was not addressed when the issues of so many

other groups were so successfully addressed as part of the amendment process.

We would hope the opposition would continue to press the government on this point if that remains necessary, because we feel strongly that this is a wrongheaded section in what is otherwise an excellent piece of legislation.

**Mr Curling:** I have another question which is a different matter. I know we try to define what an advocate would be and who would be an advocate, so to determine that, one would wonder what sort of training an advocate should have. That might be a very long question but could you give us some idea of what and who an advocate would be, and what sort of training is essential to make a good advocate?

**Mr Baker:** As you may or may not be aware, I was out of the country for a period of seven months and I was mystified when I came back to realize how issues of this kind could have become so pressing to so many people, and then I realized why that would be. I think it's because people are not familiar with what disabled people and seniors are capable of doing when they work together, and in this case I say that the structure which has been established will represent the establishment of an Advocacy Commission which will be disabled people and seniors working together on behalf of vulnerable adults.

The issue of training has been raised. The issue of role definition has been raised and so on. To my mind, what has been missing in the discussion has been a sense of respect for what an Advocacy Commission accountable to disabled people and seniors is capable of doing, and a sense of trust that they will be the best at identifying the functions of an advocate and the kind of training an advocate requires in order to effectively provide vulnerable Ontario citizens with advocacy services.

I feel strongly about this because I work for an organization which is governed by 43 organizations of disabled people, and the fact that the commission is going to be drawing from organizations of disabled people to my mind resonates with the kind of accountability I have within my organization, the kind of training my staff has and the kind of decision-making which functions within ARCH.

For me, the Advocacy Commission represents an organization which is to be respected and trusted as the voice of disabled people and seniors in this province, and should be given a great deal of leeway in the areas of role definition and training to be flexible. You can't have it both ways. If you want to define training, you want to define roles, you want to define anything, you've got a bureaucratic system. If you want to have a flexible system which is responsive to the needs of people, you can't define in specific language the kinds of training that people require.

Patrick Worth—I referred to him earlier—one of the finest advocates the province of Ontario has ever produced, has very little formal education, but he's lived in an institution, he's worked in a sheltered workshop and he's a powerful advocate on behalf of people who have been labelled “developmentally handicapped.” That's the kind of person I would be fearful an advocacy system would lose if we go about the business of defining with academic degrees and precision what we mean by an advocate. It may be



that we can, through various training programs, provide good training for advocates, but I don't think we should say now and for all time, "This is what an advocate will look like."

1650

I heard my friend John Ellis on the radio Saturday morning—John Ellis is the executive director of an Alzheimer society—saying that he hopes the advocates will receive sufficient training to be aware that people with Alzheimer's have certain behaviour traits, and I hope so, too. I think you should assume, for the same reasons you would assume that someone who works for my organization is informed when representing someone with Alzheimer's about what it is to have Alzheimer's, that an advocacy commission will want to have the advocates who are ultimately accountable to it knowledgeable about Alzheimer's. For me, that is a given. I would assume that, but I would not assume that an advocate requires a degree or formal education in order to be effective.

I would hope we could leave things where they are in trust and respect for disabled people and seniors and their Advocacy Commission—which is not the government's; it is their Advocacy Commission—so that they can establish the kinds of standards that we all know will come out of this kind of a system if it's given the opportunity to operate.

**Mr Curling:** I wasn't taking the position that advocates should have degrees; I was asking how you feel and what kind of training they should have. I don't necessarily feel that if one has a degree one then makes a good advocate or not. I know that experiences and even compassion—a lot of things—are taken into consideration. Of course, as you get a structure set up—I know you talk about the bureaucracy—sometimes we lose the human being in that process.

The other question that has been asked is whether advocates should be paid. As soon as you bring remuneration into it, should it come in, it's going to take on a different kind of direction as to who should be an advocate. This is your input, which would be important to the committee here to know what direction we should go in.

**Mr Baker:** Certainly the message I'm trying to convey is this: The system should be as flexible as possible. We don't know exactly what's going to work, but I think a commission, given the mandate to fund different models, using different mixes of staff and volunteers, different kinds of training, will be in a position, over a period of years, to evaluate what works best. But I would not want to preclude someone who has no formal education, no recognized skills but who, as you say, sir, has great compassion, from being an advocate almost in the sense of a friend, as Sean O'Sullivan said, for someone in a chronic psychiatric wing of a hospital or in a nursing home or home for the aged.

Those people don't require an advocate like the advocate required by someone who is living rough on the streets or who is in Oak Ridge at Penetanguishene. Those require different kinds of skills; they pose different demands on the advocate. To say that there is one kind of advocate we need in this province, I think is a mistake. What we have is a very broad range of needs based on cultural and regional differences, and we need to be as

flexible as possible, particularly at this stage, I believe, in allowing people to get about the business of starting to deliver this kind of service. This is an area where, if any further tightening is required, I would suggest we're five or 10 years away from being in a position to say so. I think we need to have more experience with this kind of system and we need to be erring, if we do err, on the side of flexibility rather than on the side of bureaucracy.

**Ms McKague:** Could I add one aside? This may reassure Mr Curling a bit. I subscribe totally to what David said, but just to let you know that the educational institutions of our province are in fact anticipating the need, I spoke to someone just two or three days ago who called me to inform me that, starting this September, Humber College will be offering a program in advocacy, and to give me a rough outline of the curriculum, which, unfortunately, I have not really retained, other than sort of general—it's a certificate program. One would come out with a certificate in advocacy—obviously, some of the legal issues that have to be dealt with, clinical issues, a breakdown in part of the program into advocating for a particular population so that you get some specialization. I have no idea how it's going to turn out. I was impressed with the names of some of the faculty they've lined up: very experienced and respected advocates.

So I don't think once the commission decides what it wants there's going to be a shortage of places to get it. In fact they're going to be banging the commission's door offering training.

**Ms McGregor:** In the north as well there are five community colleges who are now going to be offering an advocacy program that has been designed by a disabled woman by the name of Joanne Nother in Sudbury. This program is very exciting because it's going to be offering people with disabilities a bit more formal education to perhaps address some of the concerns that you are raising. But it is also going to give them the right perhaps to earn money to get off welfare, which all of us feel we have that right to do.

**Mr Curling:** Just to make two things clear: I'm not raising any concerns.

**The Chair:** We have two more brief questions.

**Mr Curling:** Can I just for a minute say that I raised that because I'd like, for the record, to hear your views on this. The other part: I'm not really impressed with the community colleges having a course. They seem to be jumping the gun anyhow because I think as soon as it has been defined here they will be in a better position to put the courses forward, to know what an advocate would be.

**The Chair:** Very briefly, Mrs Carter.

**Ms Carter:** First of all I want to thank you for your presentation and questions. I think it has been extremely valuable and very much in the spirit of what we're trying to do. I just wanted to pin down absolutely what it is that you're objecting to in section 15.2, because to somebody just reading through quickly, there's not much there. I take it it's the words "or is incapable"? Is that the real problem there? In section 15.2 of Bill 74.

**Mr Baker:** I'm sorry. I'm referring not to section 15.2 at this point but to subsection 15(2). The specific words I'm referring to are "except in the case of organizations referred to in paragraph 6 of subsection (1)." Do you follow me? On page 10, about a third of the way down the page, is subsection (2), and it says, "In order to participate in the nomination process, an organization must have at least 20 members, and, except in the case of...a majority of the members must be or have been persons whom the organization represents."

As a result of that, any organization with 20 members which claims to represent persons with neurological disability need not have any members who are persons whom the organization represents. To us that is a contradiction of the whole spirit of the advocacy legislation.

**Ms Carter:** Okay, I get your point, yes. So that it's not the actual vulnerable people who are going to be involved. Right.

**Mr Baker:** Exactly. Yes, thank you.

**Ms Carter:** I wanted to be absolutely clear what that was. Is there any more time?

**The Chair:** Mr Winner. One more, last question.

**Mr Winner:** Actually, my question was answered, so can I give my time to Mrs Carter?

**The Chair:** One more brief supplementary, Mrs Carter.

**Ms Carter:** I was actually talking with a group about Bill 74 this morning and they were in favour of it, they were friendly and they had a couple of concerns. One was that some people who are involved as care givers and so on who might discover people who need an advocate feel that they are subject to confidentiality rules that would preclude them drawing anybody's attention to that. Do you have any feelings on that?

**Mr Baker:** Yes. The people in that situation, in my opinion—I am confident in ARCH's opinion—should speak to the individual himself or herself and advise that person to avail himself of the services of an advocate if the person is not capable of doing that with assistance from the staff person. Perhaps we're not into an advocacy situation in those circumstances. So that's the direction in which things should be going.

There is provision of course for what's referred to non-instructed advocacy under the legislation. We certainly strongly support the circumstances in which that provision is made for non-instructed advocacy. You'll be hearing more from the Ontario Advocacy Coalition on this point. I believe it will be perhaps the primary point which the advocacy coalition will be raising with you. Not wishing to anticipate it, I would simply say that ARCH is supportive of the Ontario Advocacy Coalition on that point.

**Ms Carter:** There might be a care giver who discovers that somebody is not being well treated. They could call an advocate and hopefully there'd be no comeback against them.

**Mr Baker:** Yes. To return to the Justin Clark case, someone called up and said, "I think Justin Clark needs a lawyer." I said, "Well, that's fine that you think that; what does Justin Clark think?" That's the point we're making.

**The Chair:** Ms McGregor, Ms McKague and Mr Baker, on behalf of this committee I'd like to thank you for taking the time out this afternoon and giving us your presentation. Thank you very much.

Seeing no further business before the committee today, we stand adjourned until 3:30 tomorrow afternoon.

The committee adjourned at 1701.



## CONTENTS

Monday 15 June 1992

<b>Advocacy Act, 1992, and companion legislation</b> . . . . .	J-37
Advocacy Resource Centre for the Handicapped . . . . .	J-37
David Baker, executive director	
Carol McGregor, president	
Carla McKague, senior staff lawyer	

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## Official Report of Debates (Hansard)

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### Standing committee on administration of justice

Advocacy Act, 1992,  
and companion legislation

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

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### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

### **Index inquiries**

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### **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Tuesday 16 June 1992

The committee met at 1554 in room 151.

### ADVOCACY ACT, 1992, AND COMPANION LEGISLATION LOI DE 1992 SUR L'INTERVENTION ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervenants en faveur des personnes vulnérables; Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne; Bill 109, An Act respecting Consent to Treatment / Loi concernant le consentement au traitement; and Bill 110, An Act to amend certain Statutes of Ontario consequent upon the enactment of the Consent to Treatment Act, 1992 and the Substitute Decisions Act, 1992 / Loi modifiant certaines lois de l'Ontario par suite de l'adoption de la Loi de 1992 sur le consentement au traitement et de la Loi de 1992 sur la prise de décisions au nom d'autrui.

**The Chair (Mr Mike Cooper):** I'd like to call this meeting of the standing committee on administration of justice to order. To facilitate things we are discussing the amendments because this is the second round of public hearings. So if we keep our comments and questions on the subject of the amendments rather than the principle of the whole thing, it would make things a lot easier.

### HOSPITAL FOR SICK CHILDREN, DIVISION OF ADOLESCENT MEDICINE

**The Chair:** Our first presenters are from the division of adolescent medicine, Hospital for Sick Children. Could you please identify yourselves for the record and then proceed. You'll be given about a half hour for your presentation. The committee would appreciate it if you kept your remarks to about 15 or 20 minutes to allow time for questions and comments.

**Dr Miriam Kaufman:** I'm Dr Miriam Kaufman, a staff physician in the division of adolescent medicine at the Hospital for Sick Children and an assistant professor in the faculty of medicine at the University of Toronto.

With me is Dr Eudice Goldberg, who is the director of the division of adolescent medicine at the Hospital for Sick Children and an assistant professor in the faculty of medicine at the University of Toronto. To my far right—geographically not politically—is Dr Françoise Baylis who is with the department of bioethics at the Hospital for Sick Children and a lecturer in the faculty of medicine at the University of Toronto.

Thank you very much for inviting us back to comment on the revisions to Bill 109. We're very pleased to see that our concerns about the bill, which we expressed at the previous round of hearings, were taken seriously and incorporated into the new draft of the bill.

This being said, we are here today first to explicitly endorse certain changes to the bill, second to raise specific questions for your consideration to which we would appreciate an official comment following our presentation, and third to make one suggestion for a minor change to the revised bill.

First, we would like to say that the elimination of a specific age of consent to medical treatment is vital to the effective implementation of this bill. It is important for this government to recognize, along with the governments of Alberta, Manitoba, Nova Scotia and Newfoundland, that people are different from each other and need to have their capacity to consent evaluated on an individual basis. Those found capable of consent to medical treatment should be able to provide a legally valid consent to treatment.

Second, it is equally important for this government to explicitly allow parents under 16 to qualify to give or refuse consent to medical treatment on behalf of their children, provided they are capable, with respect to treatment. It would have been a grave injustice for this government to deny young parents this right and responsibility.

Third, the changes to the bill amending the grounds on which emergency treatment may be initiated without consent are important. No one wants this legislation to impede treatment when a patient is experiencing severe suffering or is at risk of suffering serious bodily harm.

The previous draft limited emergency interventions to situations in which a person was likely to suffer serious bodily harm within 12 hours if treatment was not administered promptly. We have two specific questions for your consideration.

First, would institutions, and in particular paediatric institutions, be able to avoid potential difficulties by refusing to provide certain services to young people based on the complexity of determining capacity and obtaining consent? For example, one could envision a paediatric hospital refusing to perform certain surgical procedures such as breast reduction or therapeutic abortion for those under 16, based on an argument that it was too difficult if not impossible to determine capacity to consent to treatment for these specific interventions. If a paediatric hospital were to do this, would it be open to a challenge under the Canadian Charter of Rights and Freedoms, sections 7 and 15?

Second, why was section 23.1 introduced? We are puzzled by the addition of this section which seems to let any health practitioner override the judgement of a family member who chooses to refuse treatment. This section of the bill seriously disempowers family members and in particular the



parents of children. There's already a provision in the bill for emergency treatment without consent and there's already a mechanism in the Child and Family Services Act for dealing with parental refusal.

Clause 37(2)(e) of the Child and Family Services Act is used by health practitioners when a procedure is considered medically necessary and the parents won't consent. This act has recently been revised to be more culturally sensitive and Bill 109 would appear to pre-empt this act, thereby removing a procedural protection for parents whose wishes, interests and beliefs may differ from those of the health practitioner.

We have, as I said, one small proposed revision to the bill. Subsection 16(10) requires that family members who are consenting for incapable relatives make a statement as to the appropriateness of their giving or refusing consent. Subsection 24(5) provides protection from liability for health practitioners who rely on the accuracy of a statement made by family members as to the appropriateness of their giving consent "unless it is not reasonable to do so."

Section 25 provides protection from liability for family members who make such a statement in good faith. Subsection 44(1) exposes family members to a fine of up to \$10,000 for any false statement.

To protect family members and to provide health practitioners with reasonable grounds on the basis of which to rely on any statement made by family members, we recommend that section 45 be amended to explicitly require of the Lieutenant Governor the prescribing of a form for statements from family members. The prescribing of such a form should not be at the discretion of the Lieutenant Governor under clause 45(c) about the prescribing of other forms.

Finally, although we are supportive of the removal of a minimum age of consent to treatment, there is no doubt that this change will introduce specific difficulties for some health practitioners. For example, the treatment of behaviourally disordered children may become more difficult as a result of this proposed legislation, and certainly the concerns raised by those who care for these children will have to be addressed.

In addition, other practitioners may have yet other concerns. Our colleagues from the medical advisory committee at Sick Kids' will be discussing some of these with you in the near future.

In closing, we remain convinced that the proposed legislation meets the needs of the majority of adolescents who, under the previous version of Bill 109, would have been inappropriately presumed incapable of consent to treatment.

1600

**The Chair:** Mr Wessenger, would you like to respond from the ministry?

**Mr Paul Wessenger (Simcoe Centre):** Yes. I think the question related, if I remember correctly, to the intention and the purpose of section 23.1. That clause was inserted to cover the situation where the health practitioner believes that the person who is authorized to give consent on behalf of the incapable person is not acting in good faith.

The concern is, for instance, supposing there's a situation where the incapable person's life could be saved by a

normal medical procedure and the health practitioner might think the person who is refusing the treatment was doing so in bad faith, because he or she might have an ulterior motive. With an elderly person and a person who might inherit—that's to give the prime example of where there might be bad faith. So it was felt necessary to give an override to the health practitioner in those circumstances where the health practitioner was of the opinion there was bad faith.

**Dr Kaufman:** This could definitely be used against families, though. The procedure that people go through now involves getting a court order in situations like that, with children, under the Child and Family Services Act.

One thing that comes up quite often is giving transfusions to children who are Jehovah's Witnesses. In a lot of cases with that court procedure, even though it's usually short and in the middle of the night, it is very important for families to be able to go back to their church and say, "The court said they had to do it." To be ordered to do that somehow or other is much more acceptable to those families than to just have a doctor decide that should be done.

**Mr Wessenger:** Yes, I understand the point you raise and I think it is conceivable. It is possible that a health practitioner in the case of, say, the Jehovah's Witness and the blood transfusion and the child situation—maybe I'll ask counsel to also comment on that aspect. Although that wasn't the particular intention of the section, I think I'll ask counsel whether they could construe that as possibly being used for that purpose.

**Ms Giuseppa Bentivegna:** The thing is that section 23.1 was inserted to cover because, it being an emergency, there wouldn't be time to question the propriety of the actions of the substitution. Therefore the practitioner or even another family member couldn't go to the public guardian and trustee to have him or her replaced, the idea being that there wouldn't be any time. If it's an emergency but the person is available to give consent, in the case of the Child and Family Services Act, that would still apply because, if it was a aren't refusing, then it would still be a case of protection and they could still go that route in the case of a child.

This allows the lifesaving treatment if there is really no time to properly question. The practitioner has to have reasonable grounds to believe either that the substitute is not acting in the best interests of the person or not acting in accordance with the advanced wishes of that person. For the advanced wishes it would have to be somebody 16 and over, so that certainly wouldn't apply to children.

**Dr Françoise Baylis:** I think our concern is not that people couldn't continue to use the provisions that are available under the current legislation in terms of finding a child in need of protection, but that you would have another alternative. We feel that perhaps this alternative is not an appropriate one, because it removes a certain kind of procedural mechanism and protection that ensures that people with different values and beliefs at least have an official forum that is supposed to be unbiased, in which they can at least express their viewpoints. The court may



find against them, but at least there is some kind of procedural mechanism.

In our understanding and reading of the bill, that procedural mechanism would not be in place in this kind of situation, or at least there would be the option of not using that procedural mechanism. It would be much quicker not to have to go through that system and justify, "We have an emergency situation and they're not acting in good faith, or, "They're not complying with section 14 and therefore we'll go ahead and treat." I think what we're trying to say is that we find that disrespectful to certain groups and potentially not appropriate.

**The Chair:** Further response?

**Mr Wessinger:** I would just say that I think it is a difficult situation. One of the difficult aspects for the health practitioner at the same time as well is the situation where there is no time to get a court order, for instance; then the practitioner is placed in a very difficult position. It is a question of balancing, I agree.

I think the practitioner would probably balance on the side of saving the life in the circumstances against the possibility of even having a civil liability. I think that would be the normal decision that the health practitioner would make, confronted with the choice of not saving a life and then being sued on that aspect or saving a life and being sued. I think the health practitioner would make the choice of saving the life and risk being sued rather than taking the other choice.

I agree that it could be utilized in the emergency situation, but whether one would criticize a health practitioner for making that decision, I don't know. I certainly couldn't criticize a health practitioner for erring on that side in those circumstances.

**Dr Kaufman:** Our other question was the one about whether an institution could make a blanket statement that, for instance, no one under the age of 16 or 18 is capable of understanding a procedure and therefore we're not going to provide it, such as therapeutic abortion.

**Mr Wessinger:** First of all, it would be contrary to the act if they did that. Second, I think there are other alternatives with respect to a hospital, particularly since I know we are going to be reviewing the whole question of the new Public Hospitals Act and the concept of the social contract. I think certainly that would be part of the social contract of every hospital, that it has to comply with the provisions of the law basically.

I would not anticipate that being a problem. I anticipate that being more of a problem with respect to an individual health practitioner. I think that is where the difficulty will arise and we need to do a good educational job with respect to health practitioners to educate them to the fact that most young people at, for instance, age 12 would be capable; most of them at 12 are capable. So I think an educational job is needed among all health practitioners. I think the medical practitioners are better educated perhaps in this area than some of the other health practitioners.

**The Chair:** Questions or comments?

**Mr Robert Chiarelli (Ottawa West):** Just a very brief comment. Dr Kaufman, I want to thank you and your

team for your ongoing participation. I think your considered study of the original bill and your original brief and your ongoing communications have made a difference to the legislation. I just want to thank you for your participation.

**The Chair:** Further questions or comments? Seeing none, Dr Kaufman, Dr Goldberg and Dr Baylis, on behalf of this committee I would like to thank you for taking the time out this afternoon and coming out and giving us your presentation.

#### ONTARIO PSYCHIATRIC SURVIVORS' ALLIANCE

**The Chair:** I would like to call forward our next presenter from the Ontario Psychiatric Survivors' Alliance of Ottawa. Good afternoon.

**Mr Terry Milne:** Good afternoon.

**The Chair:** As soon as you're comfortable, could you please identify yourself for the record. You'll be allowed about a half-hour for your presentation. We would appreciate it if you'd keep your comments to about 15 minutes and allow time for questions and comments from each of the caucuses.

**Mr Milne:** My name is Terry Milne. I'm the research and proposal coordinator for the Ontario Psychiatric Survivors' Alliance of Ottawa-Carleton. I'd like to thank the committee for inviting me back one more time. I was here on February 10. I'm hoping this is the last time I am back on this matter. I have prepared a written brief that I'm going to forward to the committee in a couple of days. I would just like to spend a few minutes hitting the high points and expressing a couple of our concerns. Some of them may incur some displeasure because I'm going to speak to our concern that we are back here again.

The Ontario Psychiatric Survivors' Alliance, for those who don't know, is an organization dedicated to providing a voice for those people who are survivors of the psychiatric system in Ontario. We are funded by the consumer survivor development initiative. There are several chapters in Ontario and one of our primary mandates is to advocate on behalf of our members and on behalf of those who are in the psychiatric system.

When I was here on February 10 with two of my colleagues, we gave tentative support to this package of legislation. That support was based on a grounding in effective advocacy. In other words, advocacy was the basis of our support for this legislation. We understood that when the minister introduced this legislation, she was quite clear that it was the basis of a package of legislation and that it would inform all of Bill 108 and Bill 109.

1610

Hugh Tapping, one of our members, was here on March 25 speaking for the Canadian Mental Health Association of Ontario, and the Canadian Advocacy Committee was here last month. Both stated a concern that I would like to state today. That is that there is a pressing and urgent need now for this type of legislation.

For too long we've been the victims of having treatments and decisions imposed on us that were later found to be to our detriment. I would like to remind the opposition parties of their support for the principles that are enshrined



in this legislation. I would also like to commend the government for having the courage to bring these principles forward.

I would like to make three points regarding this and then I'll leave it. The first is that there is a commitment to these principles by all parties. The second is that political change like this requires courage. We recognize that. All of our members do. There will be disaffected groups, and no amount of compromise will speak to all of those groups. The third and final point is that justice demands that we pass this legislation despite that and give vulnerable people in this province power over their own lives. That's all we ask for.

Previous hearings have come up with a number of useful changes to the Advocacy Act. Four which came to mind in our readings were provisions for enhanced training and accountability of advocates, a clarification of the relationship between advocates and substitute decision-makers, the strengthening of the provisions for unstructured advocacy and better and expanded access to records. Our primary concern at this point is with delay. We would ask the government to use its majority to pass this legislation without further delay.

However, now that we're here, we would like to address a couple of points that weren't looked at in the last round of hearings. The first two apply to Bill 109. In that bill we spoke the last time to our problem with the concept of implied consent. We recognized that this was a legitimate concern on the part of other groups, but for our group it has often been the basis of having treatment imposed on us. The second also concerns Bill 109; that is, to our understanding, there are no effective sanctions contained in that bill and that is something we would like to see added. Both Bill 74 and Bill 108 make adequate provision, as far as we understand, for sanctions.

Also, the last time we were here we spoke of our grave concern with thoughts of folding other programs into an advocacy commission during the implementation stage, and we would like to reiterate at this point that we would find this unacceptable. The whole point of an advocacy commission is to provide independent advocacy for our people. You can't wish away conflict of interest. If there is an institutional connection, there's going to be that conflict.

Our final point is probably the largest particular concern I'd like to raise today. Our reading of Bill 109—and we're asking for clarification from different people here—has raised an understanding that it's been proposed that in cases where incompetency with respect to treatment is being declared, people are not going to have a right to advocacy, that a rights adviser will be appointed—I guess I have a question of who would appoint that rights adviser; it's not at all clear in the revisions—and whether or not the person understood his or her rights or not, treatment might proceed. Effective advocacy demands that advocacy be provided in all cases. That should be fairly straightforward, and I think we would be unwilling to back down from this, that we feel this revision must be dropped.

In conclusion, our contingent support for the package of legislation certainly continues, but it is based as always on effective advocacy. I went over the concerns that still remain from Bill 109 and Bill 74. In closing, the point I'd

like to make is that for too long the playing field has been quite slanted. There were discussions around the office before I came down here today. The point was made that oftentimes the concept of a level playing field is a relative concept. Those that have had it slanted in their favour for a long time tend to see it as slanted against them when it becomes level. All we are looking for is the right to advocate on our own behalf. That's all we ask. We are not asking to make decisions on anyone's behalf. We are not asking for power over other people. We are asking for protection and the right to take control of our own lives.

**The Chair:** Questions and/or comments?

**Mr Chiarelli:** First of all, I want to thank you very much for continuing your communication with respect to the legislation. One of the concerns you've expressed is something that has concerned me and a number of other people; that is, at the present time there are advocates in place. A lot of them are funded through government grants or different programs. They're connected with the system in some fashion with respect to funding.

The issue is that under the current legislation there's going to be a commission established and there are going to be paid advocates, etc. I just wonder if you have been satisfied in any way that there are proper transitional features to the legislation. In other words, you may have someone who is funded as an advocate now. Will they continue in that particular role? Will their funding be rolled in and used for the Advocacy Commission? Are you satisfied in that particular area that the implementation will not be disruptive to advocates who are presently in the field?

**Mr Milne:** I'm concerned that advocates who are presently in the field may become part of an Advocacy Commission. In all fairness, I am not that clear—you've caught me off guard—on how implementation will take place. I think, in all fairness too, that certainly the Advocacy Commission has to be on the ground for some period of time before it's expected to operate, and it has to be given that time.

My primary concern is that we don't have a group like the adult protection service workers folded into the Advocacy Commission, because we want this to be much more a consumer-oriented, consumer-driven process. I don't know if that answers—

**Mr Chiarelli:** If I might add, I have talked to a number of advocates who are in the system now, fully or partially funded through government funds, and I've specifically asked the question: "Do you know how you fit into this new system? Will your funding continue? Will your terms of reference continue, or will you, in effect, become part of the Advocacy Commission?"

Quite frankly, none of them has been able to give an answer. Therefore, I'm not looking to be overly critical of the government and I would like to pose a question to one or some of the parliamentary assistants and simply ask a question: How will that transition take place? What will happen to the people who are advocates in the field at the present time? What impact studies exist or are contemplated to generate the transition? In fact, do you need a transition?

If in point of fact you're going to leave the present advocates in place, there's no need for a transition because you're going to have the Advocacy Commission come in with its new funding and its mandate and start its work. But I think the government has an obligation to everybody who's in the field—consumers, if I can call them that, as well as present advocates—to tell them what's in store.

There's a lot of uncertainty out there, and in fact one of the major criticisms of the initiative is that yes, we need advocates; we agree with it in principle and we need more of it, but how do you get from point A to point B and how do you allay the fears of people who are in the field at the present time?

I would really ask the parliamentary assistants who are here to perhaps explain that to the presenter and for my elucidation so when I hear from these groups—and I still do; they come to my constituency office or they meet us at Queen's Park and the same questions keep coming up—I would like to have answers for them.

**The Chair:** Response from any of the parliamentary assistants?

**Mr Gary Malkowski (York East):** I think it's still too early to say. We're still in the process of defining what that process will look like, but I can say to you that we will get back to you with the answer to that, but not at this time.

**Mr Chiarelli:** If I can just comment, I think that is an unacceptable answer, given the impact and the nature of this legislation. To be creating legislation which is intended for the public and which is going to impact very seriously on all these hardworking people in the field, advocates at the present time, to say that we'll get to you later and tell you how it's going to impact on you, I just think that's unacceptable. I think there's an obligation on the part of the government to start giving answers. If they expect cooperation from people who have questions and concerns, if they expect cooperation from the opposition parties in the House, if as this gentleman suggests it should be passed quickly, then I think there's an obligation to provide those answers.

**Mr Milne:** If I may for a moment, this is not the direction I hoped to raise when I made the point. Quite

frankly, I realize this is something that's going to happen on implementation and that I hope to be involved with as this unfolds. I have no concern with getting that answer today. My concern is that the Advocacy Commission remain an institutionally independent body with independent employees who can advocate effectively on our behalf and have no other institutional connections. That's my only concern.

**Mr Chiarelli:** Have you been given assurances of that yet?

**Mr Milne:** In a less than certain world, I'm relatively satisfied.

**Mr David Winninger (London South):** On a point of order, Mr Chair: I thought we agreed to extend these hearings to address the amendments to the acts. I didn't realize that we were broadening the scope of these hearings to include policy decisions unrelated to these amendments. That's why I question whether Mr Chiarelli is in order.

**Mr Chiarelli:** I am probably out of order, and I concede your point, but I thought it was a useful comment to make with respect to the legislation, particularly in view of some of the comments that were made by the presenter. I thought my comments were relevant, although perhaps technically out of order. Given the fact that we are finishing well ahead of time today, I thought perhaps you might be interested in hearing some useful alternative ideas.

**Mr Winninger:** That would be a fresh approach.

**The Chair:** Thank you, Mr Chiarelli. I might remind you that some of the amendments are policy decision amendments, so we're going to allow a little latitude in the questioning and comments. Further questions and comments?

Seeing none, Mr Milne, on behalf of this committee, I'd like to thank you for taking the time out this afternoon and giving us your presentation. I assure you that once your written brief comes in it will be distributed to all the members of the committee.

Seeing no further business before this committee, we stand adjourned until next Monday at 3:30 pm.

The committee adjourned at 1622.



## CONTENTS

Tuesday 16 June 1992

<b>Advocacy Act, 1992, and companion legislation</b> . . . . .	J-47
<b>Hospital for Sick Children</b> . . . . .	J-47
Dr Françoise Baylis, associate, bioethics department	
Dr Eunice Goldberg, director, division of adolescent medicine	
Dr Miriam Kaufman, staff physician, division of adolescent medicine	
<b>Ontario Psychiatric Survivors' Alliance</b> . . . . .	J-49
Terry Milne, research and proposal coordinator	

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- \* Winninger, David (London South/-Sud ND)

### **Substitutions / Membres remplaçants:**

- \* Owens, Stephen (Scarborough Centre ND) for Ms Akande

\*In attendance / présents

### **Also taking part / Autres participants et participantes:**

Bentivegna, Giuseppa, counsel, Ministry of Health

**Clerk / Greffière:** Freedman, Lisa

**Staff / Personnel:** Swift, Susan, research officer, Legislative Research Service

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J-8

J-8

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## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Monday 22 June 1992

### Standing committee on administration of justice

Advocacy Act, 1992,  
and companion legislation

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Lundi 22 juin 1992

### Comité permanent de l'administration de la justice

Loi de 1992 sur l'intervention  
et les projets de loi  
qui l'accompagnent



Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
Greffière : Lisa Freedman





### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

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### **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Monday 22 June 1992

The committee met at 1630 in room 151.

### ADVOCACY ACT, 1992, AND COMPANION LEGISLATION LOI DE 1992 SUR L'INTERVENTION ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervenants en faveur des personnes vulnérables; Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne; Bill 109, An Act respecting Consent to Treatment / Loi concernant le consentement au traitement; and Bill 110, An Act to amend certain Statutes of Ontario consequent upon the enactment of the Consent to Treatment Act, 1992 and the Substitute Decisions Act, 1992 / Loi modifiant certaines lois de l'Ontario par suite de l'adoption de la Loi de 1992 sur le consentement au traitement et de la Loi de 1992 sur la prise de décisions au nom d'autrui.

**The Chair (Mr Mike Cooper):** I'd like to call this meeting of the standing committee on administration of justice to order. We're resuming on the second round of presentations to the amendments on Bill 74, the Advocacy Act, Bill 108, the Substitute Decisions Act, Bill 109, the Consent to Treatment Act and Bill 110, the Consent and Capacity Statute Law Amendment Act.

### CHILDREN'S AID SOCIETY OF METROPOLITAN TORONTO

**The Chair:** I'd like to call forward our first presenters, from the Children's Aid Society of Metropolitan Toronto. Good afternoon. I apologize for the committee for the delays, but we're ready to proceed now. As soon as you're comfortable, could you please identify yourself for the record and then proceed. You'll be allowed about half an hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 20 minutes to allow some time for questions and comments.

**Dr Peggy Robertson:** Good afternoon. I'm Dr Peggy Robertson. I'm here today on behalf of the Children's Aid Society of Metropolitan Toronto. Accompanying me is Ms Heather Katarynych, who's behind me. She's the senior legal counsel for the society.

Thank you for the opportunity of speaking with you today. The CASMT has filed a submission, and you should have a copy in front of you. We ask that you consider it in addition to what I have to say. Because of time constraints, I will not be reviewing the submission point by point but will be highlighting certain issues that are important to us.

Enclosed in your copy of our submission and forming a part of it is a letter prepared today setting out the specific provisions of the Child and Family Services Act that require reconciliation with the proposed consent to treatment legislation.

Almost seven years ago the Child and Family Services Act and its regulations, all of which bind the CAS, came into force. It carefully balanced the rights of children, the rights of parents and the rights of the state. Our difficulty with the proposed consent to treatment legislation is the integration of it with CFSA. Essentially the proposed legislation tilts the balance unacceptably and in a way that undermines the rights and the responsibilities of the state to children. We have no problem with capable children being able to consent to needed treatment. Our problem is the capable child's right to refuse needed treatment.

I have been practising family medicine for 10 years, and two years ago left practice to be the medical director at the society. I left a practice filled with runny noses and relatively minor problems. Virtually none of my patients had any involvement whatsoever with the child welfare system. In comparison, when I undertake the admission medical examination of children entering society care, I often encounter apathetic children, withdrawn children, kids who are aggressive, filled with self-destructive behaviours, children who are depressed and children filled with fear. They often have a fear of retaliation by the child's abusers.

I often recognize psychiatric diagnoses, including hyperactivity, depression, psychosis, conduct disorders and oppositional defiant disorders. I frequently document physical findings, including rampant skin, ear and chest infections, sexually transmitted diseases, dental cavities, the stigmata of physical abuse, neglect and developmental delays.

Several weeks ago, at 2:30 in the morning, I was awakened by a call about a 13-year-old girl who'd been found naked in a crack house. She was unconscious, had no identification, and was rapidly taken to hospital, where emergency treatment was undertaken. She was sent to the ICU with intravenous running, oxygen on, a tube into her bladder, and many tests were performed to ascertain the cause of her coma and then to provide the appropriate treatment. Tests revealed a very high blood alcohol content.

Once this child, who was identified as Debbie, regained consciousness in the ICU, she didn't like it one bit and began to refuse any further treatment and investigation. Once fully conscious, under this proposed legislation, she would have been found capable, but she still needed medical intervention, and that's the very intervention that she refused. At a minimum, this 13-year-old named Debbie needed investigation, possible treatment of sexually transmitted diseases, treatment for alcohol abuse and treatment for the behaviours that had placed her life in jeopardy that night.



When I examine kids at Children's Aid Society, I involve them, capable and incapable alike, to the best of their abilities, in the treatment plan that I propose. This is as CAS requires me to do. When Debbie was discharged from the hospital, and she was still refusing any further medical intervention at that time, in our clinic I said: "Choose the doctor you want. Choose the time of the examination. Choose what position you want to have your gynaecological examination in. Choose what friends you want to come for moral support." But the only non-negotiable part was the gynaecological examination itself, as it was really medically indicated in this child.

The bottom line of the Child and Family Services Act is the promotion of the best interests, protection and well-being of the child. That's section 1. The CFSA is explicit that a child's wishes be taken into consideration regarding the plans of care, where the child lives, dental care, medical treatment and psychiatric and psychological services.

The CFSA is really clear that parents are responsible for making decisions about their child's needs, and should they fail in their caretaking duties, that is, they're either not functional parents or functioning as parents, the court examines the decision of the parent versus the needs of the child. We do not consider all parents who refuse treatment for their children or put children at harm mentally incapable—some are—but we do hold them accountable for their acts and their omissions.

Where the society is the child's parents, it has the same responsibilities as a parent. With the state, though, the accountability is even higher. For example, there are regulations under CFSA which specify the frequency with which a child should undergo a medical examination. The details of all this are in your submission.

As I indicated at the beginning of my talk, we are pleased to see that the proposed legislation would allow capable children to consent to needed treatment. However, if a child meets the criteria to consent, then that child surely will meet the criteria to refuse needed treatments. This is problematic for children's aid societies in fulfilling the stipulations of the CFSA. For example, children over 12 may want to refuse a medical admission under the proposed legislation, although this is required by regulations under CFSA.

In addition, further medical examinations may be prompted by disclosures of abuse once psychological or psychiatric treatment has consent or the child is safe and secure within a foster home. As we understand it, if any child objects to a medical investigation or treatment, he has the right, under the proposed legislation, to see a rights adviser. This results in a delay that may be detrimental to the child's health. How do I then, as a medical doctor, balance the child's right to call the shots, so to speak, versus his need for treatment and my duty under CFSA to ensure that child gets needed treatment? How do I balance that?

For our kids, delays in treatment may cause many problems. Children may suffer more and unnecessarily, and complications may result. For instance, a simple cavity that could be filled by the dentist may progress and turn into an abscess in the jaw.

A delay in treatment may change an easily treated condition into a chronic, debilitating one. For example, a fracture incurred when a child strikes a wall with his hand may require setting immediately, but if that isn't done, the child may have his finger heal crookedly and that can result in a long-term disability. A delay in treatment may cause death. For instance, failure to treat asthma promptly and competently can cause asphyxiation in less than an hour, and that's even before a child may be able to access emergency medical treatment.

Our kids may refuse treatment for many reasons, and they may well be capable despite their refusal. It's known that abused and neglected children may not value themselves as people who deserve help, even medical help, even in circumstances where their health is compromised. Abused and neglected children may have a high tolerance for pain as a result of their life experiences. Some children don't readily admit to having any problems whatsoever, especially teenagers, and they may deny health problems because they feel they're unworthy of help, invincible or a combination of both.

Abused and neglected children, as well as behaviour-disordered children, often have difficulties dealing with authority figures, including doctors, and may not access health care readily or willingly. Even in the face of overt and serious illness, our children may not seek medical help in a timely fashion or have the faintest idea what a timely fashion is.

This is not necessarily reflective of a lack of capacity as defined by the proposed legislation. Our kids may be able to understand information relevant to decision-making concerning their treatment, be able to spout out the foreseeable consequences and seem to appreciate the consequences of a decision or lack of one and still say no.

#### 1640

A sexually abused daughter may refuse an exam, suspecting that the results of that examination will incriminate her dad. A physically abused child may refuse an examination or ongoing treatment out of loyalty to his mother who's substance-abused. In many cases with our children, the children themselves parent the parents. This is part of the reason they make decisions the way they do. It has nothing to do with capacity as the proposed legislation is defined and it has everything to do with the way they see their priorities in life.

Assessing capacity, especially in children and particularly of kids in children's aid society care, is very complex. How are such diverse health practitioners, as defined by the proposed legislation, such as nurses and dental surgeons, trained to assess capacity? Well, I contacted the appropriate governing bodies and was informed that there is no such training for those health practitioners in assessing capacity. How then can they responsibly assess the capacity of children in CAS care who are refusing needed treatment?

Say Debbie visits a general practitioner, who finds her capable and sends her off to the gynaecologist, who finds her both in need of treatment and incapable. How does the proposed legislation decide between competing opinions of capacity? We looked for a mechanism for this in the proposed legislation but didn't find one.



We also looked for a mechanism in the proposed legislation for reviewing capacity—not incapacity, but capacity—and didn't find one. Capacity is an evolving skill starting in the latency-age child and developing further into adolescence and beyond, if it ever develops, requiring the ability to think in the abstract, forecast possibilities and project future consequences. For children in CAS care, thinking processes may be impaired because of emotional, physical and sexual abuse, sometimes neglect as well, and these are things the children may have endured in their lifetimes.

Debbie, for instance, may appear very pseudo-mature and worldly because of her abusive past but in actuality, while she may, in the opinion of the health practitioner who saw her for a quick 15-minute visit and doesn't know her, seem able to appreciate the parameters of the decision and passes the test for capacity under the proposed legislation, her refusal to consent to examination and treatment beyond the emergency treatment provided may impair greatly her short- and long-term health. Those responsible for Debbie on a day-to-day basis, who see her day in and day out, know that the last thing on her mind is concern for her own wellbeing.

The cost to this child of her refusal may be undiagnosed and untreated sexually transmitted diseases she shares with other people and which results in complications from unchecked infections. Debbie may, because of her past abuse, not even care about her own body. So what message do I, as her physician, give her if I reinforce her refusal in the face of potentially serious complications and do not seek an override to it if I find her capable as defined within this proposed legislation?

For those children in society care who, like Debbie, present themselves as pseudo-mature and capable, as defined by this legislation, there are no means to review the capacity finding itself, nor should any child in society care be labelled as mentally incapable by virtue of his refusal to consent.

For these and for many children, labels are extremely sensitive issues and to be labelled as incapable for treatment purposes alone is to be perceived by our kids as being sick in the head and it's just another deficit in their lives.

In summary, we support the right of capable children to consent to things that are designed to benefit them. We cannot support the child's right to refuse consent to treatments considered beneficial by those adults who are responsible for his care in custody, be they parents or state substitutes. The price of complying with the proposed legislation is that we disrespect and devalue these children, for whom we are responsible. We can't do that, and that's why we're here today.

Children in the care of children's aid societies are a special class, as in fact the province recognizes them under the CFSA. We urge you to promote in this proposed legislation the best interests, protection and wellbeing of these children, as the CFSA commands us to do. Thank you. Both Ms Katarynych and I are prepared to answer any questions you may have.

**The Chair:** Thank you very much. Each caucus has about five minutes for questions and comments.

**Mrs Barbara Sullivan (Halton Centre):** Thank you very much. I think we're going to want to spend some time in committee on this issue, because when the government

drafted amendments, I'm sure the problems you've raised weren't contemplated.

You're saying several things to us. One of them is that for a child in care or in secure custody to receive the appropriate care that is statutorily mandated under the Child and Family Services Act, in fact by Bill 109 that child would have to be declared incapable, and indeed some of the children who are in care could not be assessed as incapable because their problems aren't mental incapacity. They may be emotional or social imbalances for a period of time or for a longer period of time.

**Dr Robertson:** That's right.

**Mrs Sullivan:** What I'm wondering is, if you have looked at the Child and Family Services Act or the Consent to Treatment Act and could define for us what powers should be underlined in either one or the other so there isn't this conflict, so the children's rights as well as the duty to provide care are protected, whether it's through a children's aid society or in a secure home or in another area, where do you see appropriate amendments best fitting, or appropriate changes to either one or the other piece of legislation?

**Dr Robertson:** May I defer this to Ms Katarynych?

**Mrs Sullivan:** Sure.

**Ms Heather Katarynych:** We spent considerable time over the weekend doing exactly that, and it's set out in a letter dated today that's in the inside of the submission. It goes through each of the sections of the Child and Family Services Act that would require attention, whether by way of amendment or by way of integration with the consent to treatment legislation, specifically Bill 109. I don't know whether you want us to go through each of those—it's a six-page letter—but we're certainly prepared to do it if you wish that.

In addition to that, in the submission itself, at the very last tab, is a letter that was written last week to Gilbert Sharpe, the legal director of the Ministry of Health, setting out specific questions we had in relation to particular provisions of Bill 109, Bill 108 and Bill 110 as they relate to CFSA. Those two pieces of documentation in the brief itself set out the responses we would have to the questions you raise, Mrs Sullivan.

**Mrs Sullivan:** Thank you. I think it's useful to point that out for the record, because while we have the documentation, I think we're going to want to pursue this with counsel.

Could you talk about specific regulations under the Child and Family Services Act that currently affect the duty to provide care in comparison to the rights of children?

**Ms Katarynych:** Yes, we're happy to do that, if I could just get a copy.

**Mr Norman W. Sterling (Carleton):** While you're doing that, could I just have a supplementary? In terms of the amendments, are the amendments that have been introduced the things that triggered your concern, or was it before that?

**Ms Katarynych:** Yes, they were.



**Mr Sterling:** Which specific amendment was it? The 16 to 12?

**Ms Katarynych:** May I address that?

**Mr Sterling:** Yes.

**Ms Katarynych:** It was the removal of the presumption. We were aware certainly of the legislation as it was moving forward through its various stages, and that there was in that legislation the presumption: 16 and over presumed capable, rebuttable; 16 and under presumed incapable, also rebuttable. Although there were some concerns that we had around how that would operate within the context of the CFSA, the rebuttability portion was for us sufficient to work within the difficulties.

We were caught by surprise when the presumption was removed. We were advised that that had happened actually on May 4 and we were invited to a consultation chaired by our ministry and the Ministry of Health representatives from those two ministries that alerted us to the reasons for the change and basically the impact. It was at that point in time that we began our analysis of those particular changes on the legislation that binds us. That's what has prompted our appearance now.

**Mr Sterling:** But if it was still 16, would you be making the same presentation?

**Ms Katarynych:** It was the presumption that children 16—

**Mr Sterling:** Okay, I know that, but if the legislation was as it was, you wouldn't be here today?

**Ms Katarynych:** No, we would not, because we would be attempting to work within the presumption relying on the rebuttability to deal with those children who would otherwise be capable or incapable and looking at having that addressed in a review. But it was the removal that caused the problem.

**Mr Sterling:** If the common law were in place, that would be adequate?

**Ms Katarynych:** No. Our position on—

**Mr Sterling:** That's what you're operating under now?

**Ms Katarynych:** No, we aren't. We're operating on the common law as we interpret it to have been overruled by specific provisions of this statute, by inference from all of the duties in the statute that rest with parents and state care providers. To that extent, we regard those duties as abrogating those aspects of the common law that get in the way of that.

We understand that to have been the exact intention of this province when it put into the Child and Family Services Act the specific duties on service providers that it did. The whole point was to make them very highly accountable for the delivery of service. Which meant there had to be a very careful balancing of the rights.

**Mr Sterling:** I'll forgo my time.

**The Chair:** Mrs Sullivan, you still have two more minutes left.

**Mrs Sullivan:** I could have started back there, but I wanted to follow along to ask the presenters again to speak to the conflict between—the requirements of the regulations under CFSA in providing the duty to care specifically that

are now affected by the changes to the consent or the amendments presented to the consent bill.

**Ms Katarynych:** In the regulations themselves, there are two regulations made under the Child and Family Services Act. One is 550/85 and the other one is 551/85. The particular regulations that are directly affected are in 550/85, sections 65, 66, 67, 77, 78, 79, 84—beginning at 84, the regulations speak directly to medical and dental care—85, 86, and then in relation to foster care, 103, 104; over then to regulation 551/85, which specifically addresses children's aid societies on issues of medical and dental treatment as well as psychological and psychiatric assessment and treatment—section 4 of Ontario regulation 551/85.

All those regulations are designed to reinforce provisions in the Child and Family Services Act that relate to the delivery of service to the children. Many of the components that are now defined as treatment under Bill 109 impact on those. We set those out in detail in our submission to you.

**The Chair:** Thank you, Mrs Sullivan. Further? Mr Sterling.

**Mr Sterling:** I guess the basic conundrum we find ourselves in is that we had many people who were involved in the counselling of young people who were capable and did not want the presumption of those young people being incapable. In particular it dealt with young women who were going to seek independent medical advice. I guess we're caught in a bit of a conundrum here. I understand the purpose of the act is to empower the individual as much to make the consent, and basically your argument is that even though a person is capable, we want to withhold that empowerment.

**Dr Robertson:** No, that's not our argument.

**Mr Sterling:** You're saying within the CFSA in effect—I'm not disagreeing with you necessarily. You're saying that for the good of this individual, you want to be able to have individuals treated in spite of the fact that they don't want to consent to the treatment.

**Dr Robertson:** The flip side of being able to consent to the treatment is the ability to refuse.

**Mr Sterling:** Yes, I understand.

**Dr Robertson:** We often find that for many reasons, while the child may be capable, he will refuse a needed treatment. Because we are obliged under the CFSA to protect children and work with them to secure their best interests and their wellbeing, physically, emotionally and otherwise, sometimes we have to insist on treatment. If we have no power to insist on treatment where that's necessary to secure the wellbeing of the child, we're unable to fulfil our obligations.

**Mr Sterling:** I guess I'd make that argument with a number of other—that doesn't only hold for children.

**Dr Robertson:** Absolutely.

**Mr David Winninger (London South):** I appreciate the views you've expressed but I have a little bit of a problem with the legal position you're taking. In my former life I represented children in child welfare proceedings and one of the biggest problems then was how you can enforce



treatment on a child who is capable of refusing appropriate treatment.

Quite frankly, I can't see how these amendments change in any way the basic common law position, which was that a child who is capable can either consent to or refuse treatment. That even extended to the juvenile justice system where young people who were the subject of court orders and who were found guilty could not be ordered to have appropriate treatment that might change the whole course of their lives. I'm just wondering how these amendments we're putting forward change what is right now the status quo to the detriment of children.

**Ms Katarynych:** First of all, the statute under which we operate is a protection and care statute, and when it was amended to the extent that it was when it went into force in November 1985, in providing a number of very specific duties on children's aid societies and other care providers to deliver a certain standard of service, it basically provided then a scheme by which once in care any right a parent might have, let alone any right a child might have at common law, we interpreted to be an abrogation of the common law right. The price of not interpreting it that way was an inability to carry out those duties under the statute and would in fact be the inability now.

**Mr Winner:** I agree if you have a wardship order the rights of the parent to consent are supplanted by the agency.

**Ms Katarynych:** Yes.

**Mr Winner:** But the rights of the child, when capable, to refuse or consent to treatment were not necessarily supplanted, were they, by the children's aid society?

**Ms Katarynych:** They were not done specifically in the statute by a provision that addressed that. How they were done was by inference from those sections that provided the duties, because if you work on the basis that every act is remedial and that the whole point is to ensure its object and its intent and you keep in mind particularly the public consultation that went on at the time that dealt with the standard of care to be delivered to children, those provisions of the statute, by inference, we interpret to override the child's consent to refuse the way we interpret them to override the parent's right to refuse under common law. That's how we carry out the objectives of the statute.

**Mr Winner:** I understand your position.

**Ms Katarynych:** Except where CFSA provides otherwise.

**Mr Winner:** I know my colleague has a question.

**Mr Paul Wessinger (Simcoe Centre):** I just have some difficulty with this suggestion you put forward to try to distinguish between the right to refuse treatment and the right to consent to treatment. It seems to me that you have the right to deal with treatment either by refusing it or accepting it and you can't really distinguish between the two. I don't see any legal basis for that and I'd just like to ask you if you'd agree with that: that there's no legal basis.

**Ms Katarynych:** That's our difficulty as well. We would like to see the consent to treatment go forward. It's only the refusal that we have a problem with. If the refusal

is going to cause harm—I'm sorry, I don't understand how that is amusing. We set out in our recommendations how we would see the harm and the refusal being dealt with in a way that would balance that child's rights, short of allowing him to have autonomy where it's causing him harm.

**Mr Wessinger:** I'm just saying, as a lawyer, I can't see any court dealing with the difference between a person making a decision of refusing treatment or consenting to an actual treatment. To me, it's one and the same and I don't think in law you can make that distinction. What you're advocating then is the position that the children's aid should override the right of a capable child to make decisions concerning his treatment. Is that really what you're advocating, that it should override because—

**Ms Katarynych:** All service providers who have duties and responsibilities that are mandatory under the Child and Family Services Act, which includes the Children's Aid Society, yes.

**The Chair:** Dr Robertson, Ms Katarynych, on behalf of this committee I'd like to thank you for taking the time out this afternoon and giving us your presentation.

1700

#### FAMILY ASSOCIATION FOR MENTAL HEALTH IN ETOBICOKE

**The Chair:** I'd like to call forward our next presenters, from the Family Association for Mental Health in Etobicoke. Good afternoon. Just a reminder from the committee that you'll be allowed a half-hour for your presentation. The committee would appreciate it if you keep your remarks to about 15 or 20 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable could you please identify yourself for the record and then proceed.

**Mr Bill Sande:** I'm Bill Sande, chairman of FAME, and this is Judy Wallace, our coordinator, who is going to speak to the amendments.

**Ms Judy Wallace:** Thank you for this opportunity, ladies and gentlemen. I'd like to start with a series of notes, which is the single sheet we gave you, with comments from some of our members who were not able to come but had very specific concerns.

The tenor of this package of legislation seems to come from a narrow perspective of rights—rights as isolated from responsibilities. It is important to protect individuals from potentially abusive, demeaning or disempowering situations. However, to concentrate on rights only leaves those same people even more vulnerable.

Responsibility entails not only the ability to make a decision but to truly understand the impact of those consequences that result from a decision and to be able to adjust one's life to those changes.

The advocate's role as defined in these acts can in many circumstances provide a partial picture to someone who is ill, which can exacerbate the illness. The advocate also seems required to inform the individual that wishes and directions expressed earlier can be overturned. It appears the protection that is offered through the power of attorney



is only valid so long as the individual continues to agree, whether well or ill.

In many situations of mental illness, without a knowledge or history of the individual under assessment, he or she can incorporate this process into a delusional system and thus appear competent rather than be competent, thus undermining his or her own wishes. In this assessment of capacity, the definition is sufficiently vague to result in situational implementation that will vary perhaps widely, as now happens from one medical practitioner to another.

This new legislation appears to create yet another set of legalistic, bureaucratic barriers to treatment. It also assumes that anyone who is seeking treatment, or to treat a person with an active mental illness, is doing so from an adversarial position. There have been instances in which the treatment rendered to an individual was not appropriate. However, in the protection of the few we seem to be putting the many at greater risk.

The next, which is the larger package, is what our organization has put together.

The purposes of this bill, Bill 74, are laudable. However, there are assumptions made that do not reflect an accurate assessment of the existing situation. Again, this bill assumes that an adversarial situation always exists between mental health survivors and the mental health system; between mental health survivors and their families; between families and the mental health system. Although this may be the case in some individual situations, it does not accurately reflect what many families and their ill relatives feel. The enactment of legislation to protect these few disregards the needs of many.

The role of the advocate is still being enacted in a narrow, legalistic presentation of a complex situation. If the advocates were instructed and directed to assist the individual in assessing the whole situation and the long-term ramifications of a decision, then their role would be seen as responsible and sensible. However, nowhere in the existing situation—with advocates in the provincial hospitals—or in this proposed legislation is there any indication that the advocate's role is to present a balanced view of the existing situation. One can only assume that the advocates with the current job description will continue to fulfil the role in the traditional way. That is not to say that individual advocates do not act responsibly.

The advocate should, when explaining the individual's rights, also outline the individual's responsibilities. Those responsibilities include a realistic consideration of the consequences of any decision to accept or reject treatment or any part of treatment, to remain in hospital or to leave, and to accept responsibility for accommodation and basic needs. No decision that is made can be implemented without affecting other aspects of an individual's life. Although the advocate is mandated to assist the individual to make a decision based on rights, the exercise of those rights must be viewed in terms of the attendant risk factors. Those factors may include housing, income, ability to meet basic needs, impact on significant others and the adequacy of the existing support system.

The Advocacy Commission is composed entirely of survivors with no consideration of the advocacy needs of

families. The establishment of a committee to advise the commission on which families may sit, paragraph 10(2)1, does provide for a family voice but one with no teeth. Families have experience in participation on community advisory boards and committees for a number of organizations. We have found that although family views are accepted graciously, their impact is at best minimal. If an advisory committee is to have a purpose, it must have a mechanism for ensuring that concerns and recommendations have some authority in relation to the commission and the ministry.

This bill also proposes yet another committee: one to choose the commission. The criteria for membership on this committee is also outlined and appears to be composed of representatives of vulnerable persons. Once again we must protest the exclusion of family groups, unless of course family groups are included in clause 13(1)(b), those appointed by the minister. However, given the tenor of the bill it would seem that families will be disregarded.

Families represent the largest single group of care givers. They are unpaid, expected to perform their jobs prior to any training, given little access to training and available when no one else is. Although there are groups like FAME that do advocate both individually and systemically for and with families, with the increasingly legalistic process involved in obtaining mental health services, an advocate mandated by the government to address family needs, support family organizations and represent a family's perspective is critical. The provision for family education and training in clause 7(5)(b) is important. However, it is not enough. As families advocate for their ill relatives, the support and backing of a trained advocate is essential.

The bill states that the role of the advocate is "to acknowledge, encourage and enhance individual, family and community support for the security and wellbeing of vulnerable persons." Would this not be more easily accomplished if there were family representation on the Advocacy Commission instead of creating another committee to provide advice?

Families, like survivors, need their own groups to work exclusively for their needs and issues. But like the survivors, their input and access to the system needs official support. Families also need the recognition and protection in law that ensures that they will not be abused by those professionals involved with their ill loved one. They also need a method of recourse that protects their ill relative from retaliation. Families have often been afraid of confrontation with the mental health system for fear that the negative impact of their complaints and concerns would be meted out on their loved one, either while in a care situation or through reputation when care is required again. Although no one wants to recognize that this situation occurs, families are only too painfully aware of this risk factor.

#### 1710

Clause 7(1)(k) calls for the establishment of a code of conduct and for the minimum qualifications of advocates. We at FAME are interested in the criteria for this position. The individual who would take on this role must possess the skills of many professionals. Furthermore, the individuals accepted as volunteer advocates must be provided with the same training as paid staff. Volunteers must be



held accountable for their actions under the terms of the act and be liable through the courts for negligence and/or unprofessional conduct. This is necessary so as to arrest any hasty or indiscriminate actions on the part of staff, paid or volunteer. Will families be trained and included under the category of volunteer advocate?

Training of vulnerable persons, families, social service and health workers etc will have to be an extensive, ongoing process, both to provide training to new individuals and re-training as legislation and policy changes. How will this training be provided? Who will administer the courses? What will this cost? How will resistance from special interest groups be addressed? Might I direct your attention to the letter from Dr Ingram published in the *Toronto Star*, June 11? Dr Ingram describes a potential horror story, as did other doctors when the committee was meeting to hear the presentation on the original bills.

What measures will the government take to train doctors and the general public on the realities of this legislation? Those of us who have had to live with the reality of medical displeasure with the Mental Health Act can look forward to another version of Dr Ingram's horror story, with the health care professionals insisting on the full range of paperwork ahead of any treatment and a passive resistance to compliance.

One final concern relates to the cost of implementing as extensive a program as this bill envisions. How will this be done, with what moneys in times of recession and government cutbacks? Without an implementation strategy outline, it's difficult to assess the cost and therefore the impact. Finally, in determining the number of advocates we wish to see that such criteria as multiculturalism, population size and geography be implemented. The remuneration of the committee will also be paid by fixed daily rate plus reasonable expenses, subsection 13(5). This method of administering the advocacy program seems rather generous in times of restraint. Perhaps a less costly method of salary plus approved expenses would be more fiscally responsible.

Bill 108 outlines the requirements for a judgement of capacity that takes into account the appreciation of the consequences of action or lack of action. It, however, does not provide any guidelines or qualifications for that appreciation. Although section 46 states that "A person is incapable of personal care if the person is not able to understand information...relevant to making a decision concerning...health care, nutrition, shelter, clothing, hygiene and safety," it does not outline any criteria for this determination.

For instance, if a person wished to be released from hospital, what standard of self-care would apply? If no arrangements had been made regarding shelter or nutrition, would the person's assurance that he or she would take care of that later be sufficient; would proof of some sort be required regarding current skills be needed; would refusal to submit to a voluntary assessment indicate competency or incompetency? Without guidelines for decision-making, it's difficult to assess whether this proposed bill is helpful or not for those attempting to work with and support persons whose competency may be fluctuating.

Although the bill clearly outlines power of attorney and guardianship for property and personal care, it's still unclear whether these sections would fall under the same application, whether they would fall into different jurisdictions or different people. It's important to provide a process that would permit both possibilities, as in many instances of mental illness control over fiscal matters can become a very contentious issue, best left to the control of strangers, whereas personal care often needs the historical connectedness of family who will remain involved.

We wish to express concern regarding the use of the word "force" as stated in paragraph 50(1)4. Within the context, force essentially implies the exercise of physical energy. If we substitute the word "action" it does not substantively change the meaning; rather it broadens it to include physical, mental and emotional persuasion.

Subsection 50(6) appears to be a lengthy, complicated process. From our experiences, individuals with a mental health problem have extreme difficulty maintaining the patience required to carry through these transactions. It is our desire to see the time frame streamlined to a seven-day registration period. The lengthy time involved serves to protect the individual; however, it may also work to his detriment. Continuing in clause 50(6)(c), the facts upon which opinions will be based must be set out. Will the assessors have clear guidelines? What form of compensation? Will it be OHIP-based? How will this be presented to the psychiatrist? Is it possible for a general practitioner to do this instead?

Under Bill 109, consent to treatment, as outlined in the Mental Health Act, is similar to what is being proposed in this act. The difficulties experienced by those implementing the existing legislation seem to have had no impact on the development of Bill 109. In many instances of psychosis, the ill individual is capable of incorporating the assessment procedure into his or her delusional system, thus appearing quite rational. If the exhibiting behaviour were placed in context, ie, psychosocial history from previous assessments, if existing, and file notes or reports from physicians of record and/or family, then a more accurate assessment could be made by the attending physician.

Although informed consent is always the preferred methodology, it is not always the feasible option. In the proposed bill, the provision for determining capacity, ie, 6(1) "able to understand the information that is relevant to making a decision concerning the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision," does not consider that acceptance of a poor consequence may be a reflection of illness rather than real understanding. Again, there's no benchmark to measure the individual's understanding of a situation. In other words, is this the kind of decision that this individual would make in normal circumstances?

It's been noted that the concerns about reversals of decisions written into the power of attorney will not supersede the existing document if the decision is made during a period of assessed incompetence, section 47.1(2). Within Bill 109, subsection 14(1) requires a definition of "best interests." Although it is necessary to remain flexible regarding various circumstances or the environment, the phrase as it



stands is subject to individual interpretation. Likewise, the notion of severe suffering or severe pain, which would override consent, section 22(1), must be properly defined.

In developing comprehensive legislation to ensure protection of the rights of vulnerable persons, it would appear that some basic rights have been overlooked. For those individuals residing within an institutional setting, no protection from the hazards of institutional life have been developed. For instance, what protection does a resident of a psychiatric facility have against contracting AIDS or other communicable diseases? Residents also face situations of assault for which the only recourse is an after-the-fact criminal charge. If we are so concerned about rights, perhaps we should also consider the right to be ensured safe and adequate treatment.

This bill creates a bureaucratic nightmare regarding interpretation and implementation of policy. How will those in the social services field be made aware of their roles and actions within the scope of the proposed legislation and onwards? Where will the money come from for the training programs to educate employees? Furthermore, it is possible to envision a situation in which an individual receives inadequate care or attention as a result of the inability to locate the next of kin or obtain a consent to treatment.

Bill 110 is clearly a housekeeping bill intended to amend a vast range of legislation so that it is all consistent with the preceding three bills. However, we continue to question how all those who work within the range of legislation from the Drainage Act to the Mental Health Act to the Child and Family Services Act will be aware of the implications of the proposed changes. Will materials be developed for those not trained in jurisprudence that will explain in clear, simple language what the bills mean, who is affected and how these bills affect other bills?

Finally, what provisions are being made to assist the medical profession to accept these changes as a routine part of their work? Those who have encountered the response to the Mental Health Act are aware that many psychiatrists adopted a stance of narrow, legalistic interpretation that paralleled work-to-rule. Further legal requirements may have the effect of reducing the possibility of treatment, even for those who are requesting treatment in a clear manner.

The basis for this proposed legislation is clear, both as a change in philosophy and a response to court decisions. However, for the families, individuals and professionals who will have to work with yet another set of laws, the mental health system is beginning to feel like a large onion: For each layer that is peeled away, there is yet another layer to peel. A system that becomes excessively complex to access has the effect of reducing access as well as ensuring protection. Is there not a way to provide a comprehensive piece of legislation that protects and provides access without needing a law degree to get help? We recognize that a great deal of thought and work has gone into the revision of these proposed pieces of legislation, but the net result feels like more procedure to cover less content.

**The Chair:** Thank you very much. Mrs Sullivan, you have about four minutes.

1720

**Mrs Sullivan:** I think you probably heard the presentation from the Metro children's aid society just before your appearance, and I think a number of the issues you have raised are also affecting that organization in terms of determining the relative balance between the right to civil rights advice and the right to health care, and attempting to reach that kind of balance through development of legislation that has heretofore been under the common law.

I wonder if you could comment, because you have gone through the three different bills, on your response to the various definitions of "capacity".

**Ms Wallace:** It certainly was interesting. That's part of the difficulty; that there isn't a clear enough definition or a single definition throughout that allows you to say, "Okay, here it is." So every practitioner you might go to, or every hospital you might go to, could say, "Oh, well, we're using this act and this is our definition, so you don't qualify" or "this doesn't qualify." For people who are looking for treatment particularly in crisis situations, which is when help of that nature is normally sought in mental illness, to be faced with a collection of definitions on whether they are competent or not competent exacerbates the situation quite dramatically. It's difficult enough going through the emergency wards, but to have to face a pile of different definitions on what constitutes competency I think puts people in a much worse situation.

**Mrs Sullivan:** The children's aid society also talked about the emotional effect and/or negative effect on young people who, in order to receive treatment, would have to be assessed as incapable. Do you see those situations in the families with patients you are involved with?

**Mr Sande:** Yes, definitely. From my personal experience, I think what it does is lower the individual's self-esteem to be judged incapable. Indeed, I see it as a real problem.

**Mr Sterling:** As to the part in your submission with regard to the role of the family and the advocacy role, are you saying a family advocate has to have the same degree of training and expertise as a professional advocate? Is that the view you're putting forward?

**Ms Wallace:** When we read the act and it talked about volunteer advocates, there wasn't any definition of who that would be or how one became one or what training would be provided for volunteers. But if there were going to be paid advocates and volunteer advocates, and presumably families would fall into the volunteer advocate category, surely to goodness we shouldn't set up a two-tiered system so that if you get a paid advocate you get professional, trained advocacy and if you get a volunteer advocate you get Aunt Hattie down the street.

**Mr Sterling:** It cuts both ways. One of the problems with trying to escalate the qualifications for an advocate too high is that you're probably going to take out the people who have the greatest interest in these individuals.

**Ms Wallace:** Excuse me. We weren't talking about qualifications for the job; we were talking about training. No, I wouldn't necessarily say that everyone who is an advocate has to have a law background.



**Mr Sterling:** I think the problem with the act—and I don't know whether you have considered it in your submission or were considering it when you were drawing it up—is that there's nothing that hauls the advocate into line, be it a volunteer advocate or be it a professional advocate of the commission. I think the accountability of the advocate is a problem with this act. If somebody is acting way out of line, the commission, which is biased, is going to make the decision as to whether the advocate is out of line. To me, there is no sense of justice to the family who considers that an advocate has stepped way out of line, or if somebody else, a health care provider, considers that an advocate has stepped way out of line and beyond his or her expertise, there's nobody you can go to in this act to have your grievance heard.

**Ms Wallace:** We did comment on that and we are concerned about that. We don't feel that in order to deal with an advocate behaving in a way that may be detrimental to a client, the client should have to go to court for redress. That's complicates and complicates and complicates a situation that shouldn't exist in the first place.

**Mr Sterling:** So you'd support a discipline committee made up of laypeople who were at arms' length from the commission or something like that?

**Ms Wallace:** Yes.

**Mr Sterling:** Okay. Thank you.

**Ms Carter:** I want to speak mainly to Bill 74 and advocacy. I think there's a basic misunderstanding here, and it's one we've had a lot throughout the hearings on this; that is, what the object is of these bills and particularly of Bill 74. It's a question of power. The object is to empower the individuals themselves, the persons who are vulnerable or whatever.

Now, most of the time the interests of the family or care givers or whoever and that of the vulnerable person are going to be the same, and there's no problem with advocates working with those people. That's been made clear from the outset and has been further clarified, I think, in the amended version of the act. But the bottom line is that sometimes even family and even care givers can neglect, ill-treat, exploit or simply not listen to and follow the wishes of the actual person, so I feel that has to be the basis of what we're doing here.

There are some other things that I think have been to some extent misunderstood. Advocates won't be an untrained horde, but they won't be legal experts either. They're not going to be lawyers. The training has been left up to the Advocacy Commission, which itself is going to consist of people with very, very close links with vulnerable groups. That is why we don't want it to be a bureaucratic thing; we want it to be something that comes from people who understand.

Volunteers can certainly be advocates. They won't be paid, but they will have to be trained, and anybody who sets themselves up as an advocate who does not have the certification will be subject to penalties; that you cannot make that claim unless you have gone through the requisite training, whatever it turns out to be.

Right at the beginning, you raised the question of the person who appears to change his mind when he's actually

not capable and refuses treatment on those grounds. I think that has been thought of too in what is called the Ulysses clause, where a person can state in advance, "I wish to have a certain kind of treatment, and if, when I'm incapable, I say the opposite, you will disregard it," and that can be made to stick.

I also mention the articles by Jenny Ingram. It so happens that she resides in the same part of the world I come from, Peterborough, and we've had certain exchanges in the local press. I have met her. Jenny Ingram was herself under some misapprehensions, which were actually retracted in the Peterborough Examiner.

I also hope you have read the revised version of the act with the amendments in it, because I think that does answer some of the problems you're raising.

**Ms Wallace:** If you look at what I said about Dr Ingram's letter, what I asked was, how will resistance and special interest groups be addressed? In other words, both at the previous hearings and at the beginning of this hearing, there have been letters to the editor and a section—I believe it was a big section in yellow in the Star—outlining the horrors of four-year-olds refusing inoculations and that sort of thing. When there's that kind of resistance, the kind of response that happens with the enactment of legislation is not a positive thing.

There was resistance to the passing of the current Mental Health Act, and a lot of the psychiatrists—certainly not all, but a lot of them—have acted as if it's a burden, and the less they have to do about it the less they're going to do about it. So if we have more legislation that doctors are opposed to, how is this going to be addressed? We've already had the experience of it not being addressed adequately with the Mental Health Act. How will it be addressed with three new pieces of legislation? Is somebody going to go, doctor to doctor, around the province and say, "This is what it really is"?

**Mr Gary Malkowski (York East):** I appreciate your concerns as they relate to the omission of family participation, but we do have an amendment under clauses 15.2(a) and (b) and also subsection 15.3(2) which provide a role for family as chosen by vulnerable people. How do you feel about that amendment?

**Ms Wallace:** You have me at a slight disadvantage because I don't have the act in front of me. It has been traditional within the Mental Health Act to be able to list family as advocate, and the difficulty we've experienced with the Mental Health Act in that is that some doctors will recognize family as the appropriate advocate and some doctors won't, so who do you know who you're dealing with in the middle of a crisis? I mean, you don't go to hospital emergency with a collection of acts under your arm. Hopefully, you go with a medical health card and not much else.

It's a situation that says, "Sometimes you can be and sometimes you can't be, and I, as a medical practitioner, will make the decision on whether you're the right advocate or not the right advocate and whether I'm going to talk to you or whether I'm not going to talk to you." This



is a situation that families face continually in dealing with the medical system.

**Mr Malkowski:** What would you recommend, then, to those who have no family and that kind of support system; what would you propose to help them?

**Ms Wallace:** For those without families?

**Mr Malkowski:** Yes.

**Ms Wallace:** For those without families, most people would have the opportunity to appoint someone they trusted, and if there is no one someone trusts to that capacity then

obviously that can be dealt with by an advocate with directions specifically written out. The act does provide for that.

**The Chair:** Thank you, Mr Malkowski. Mr Sande and Ms Wallace, on behalf of this committee I would like to thank you for taking the time out this afternoon and giving us your presentation. Having no further business before the committee this afternoon we stand adjourned until 3:30 tomorrow afternoon.

The committee adjourned at 1733.











## CONTENTS

Monday 22 June 1992

<b>Advocacy Act, 1992, and companion legislation</b> . . . . .	J-53
Children's Aid Society of Metropolitan Toronto . . . . .	J-53
Dr Peggy Robertson, medical director	
Heather Katarynych, senior legal counsel	
Family Association for Mental Health in Etobicoke . . . . .	J-57
Bill Sande, chairman	
Judy Wallace, coordinator	

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- \*Sullivan, Barbara (Halton Centre L) for Mr Mahoney

\*In attendance / présents

#### **Also taking part / Autres participants et participantes:**

Sterling, Norman W. (Carleton PC)

**Clerk / Greffière:** Freedman, Lisa

**Staff / Personnel:** Swift, Susan, research officer, Legislative Research Service

J-9



J-9

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## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Tuesday 23 June 1992

### Standing committee on administration of justice

Advocacy Act, 1992,  
and companion legislation

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Mardi 23 juin 1992

### Comité permanent de l'administration de la justice

Loi de 1992 sur l'intervention  
et les projets de loi  
qui l'accompagnent



Chair: Mike Cooper  
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### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

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### **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Tuesday 23 June 1992

The committee met at 1542 in room 151.

### ADVOCACY ACT, 1992, AND COMPANION LEGISLATION LOI DE 1992 SUR L'INTERVENTION ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervenants en faveur des personnes vulnérables; Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne; Bill 109, An Act respecting Consent to Treatment / Loi concernant le consentement au traitement; and Bill 110, An Act to amend certain Statutes of Ontario consequent upon the enactment of the Consent to Treatment Act, 1992 and the Substitute Decisions Act, 1992 / Loi modifiant certaines lois de l'Ontario par suite de l'adoption de la Loi de 1992 sur le consentement au traitement et de la Loi de 1992 sur la prise de décisions au nom d'autrui.

**The Chair (Mr Mike Cooper):** I'd like to call this meeting of the standing committee on administration of justice to order. We're still in the second round of public hearings on the amendments to Bill 74, the Advocacy Act, Bill 108, the Substitute Decisions Act, Bill 109, the Consent to Treatment Act and Bill 110, the Consent and Capacity Statute Law Amendment Act.

### DYING WITH DIGNITY

**The Chair:** I'd like to call forward our first presenters, from Dying With Dignity. Good afternoon. Just a reminder that you will be allowed a half-hour for your presentation. The committee would appreciate it if you would keep your remarks to about 15 or 20 minutes to allow time for questions and comments from each of the caucuses. As soon as you are comfortable, please identify yourself for the record and then proceed.

**Ms Marilynne Seguin:** My name is Marilynne Seguin and I'm the executive director of Dying With Dignity. I would like to introduce you to Martin Campbell, a barrister and solicitor with the firm of Beard, Winter who advises Dying With Dignity on occasion on certain matters, and Nancy Mills, who is with the firm of Mills & Mills and has recently come on the board as a director and officer of Dying With Dignity.

The first thing I would like to do is compliment the various people who have worked so hard. The 199 amendments are an awful lot of work. We support the bills, as we said in our previous brief. We still have a few concerns,

however, but we will limit ourselves to mentioning one or two items.

We would like to emphasize that the support shown between care givers and family members to all Ontarians receiving health care is very credible and pleases our organization immensely. Our particular concerns, however, are related to those who are terminally ill.

Martin, would you like to comment?

**Mr Martin Campbell:** I trust you have the letter we sent to Norman Sterling. This should be before you. Attached to that letter is also a one-pager with the word "Harm" at the top. I thought we could perhaps go through this letter and then reserve most of our time for questions.

In the letter of June 12 to Norm Sterling we made perhaps three basic points on the first page. Our first comment is the complexity of the legislation, which in terms of both the policy and process and the language used to define that process in our view remains a problem. All we can do there is urge you, wherever possible, to move to as plain language as possible and to find ways to streamline. That really goes a bit beyond our specific interest, however, but it's a general comment which I think we feel comfortable making.

Second, as Marilynne mentioned, we are strongly in support of the amendments contained in section 63 of Bill 108, which requires guardians to take into account values and beliefs of the person under their care and to foster regular personal contact with the incapable person, family members and friends. In our view, this is a critical and very valuable amendment, because it emphasizes the need for full family support and understanding of an individual person.

Third, we have a technical issue we're a little concerned about. Here, even though I'm a lawyer and know something of the health area, I defer to your own legislative counsel and counsel for the ministries involved. As we read it, we fear there may well be an area of uncertainty respecting the use of the word "treatment" and the possible distinction between the word "treatment" and personal care. We've set that out in some detail in our letter. I don't think there's much point in my reading that, but I ask that you put that issue before legislative counsel and before counsel for the Ministry of Health to see whether our concerns are valid. If they are valid, then there're some suggested changes in the middle of page 2. Make sure that the concept of health care is clearly included in the concept of treatment.

Our fourth issue is also set out on page 2 and has to do with the notion of harm. Here we are really dealing with a philosophical or conceptual issue which concerns us. If you turn to the single sheet of paper you'll see a statement of how the word "harm" can be perceived. The context is paragraph 14(2)(c)3 of Bill 109.

We are concerned that the use of the word "harm" would preclude action or lack of action on behalf of someone



who chooses to forgo treatment which is available, and the concept of "harm," as traditionally interpreted in our society, means death or further disability. We would like to make certain that the word "harm" is drafted in such a way that it would be clear that a person who has chosen to refuse treatment is not going to be the subject of "harm." That, again, you can put before legislative counsel and solicitors for the ministries and say, "Is this concern justified?" We would value the amendments in that area.

Those, very briefly, are the several points we felt we would make orally. We've tried to cut our presentation to you down to the bare bones. The overriding concern is that the legislation be passed as promptly as possible because there are many people who require a legislative framework to support and buttress the decisions they have made in advance directives or in living wills. Those are our comments; we are prepared for questions.

1550

**Mr Alvin Curling (Scarborough North):** As you mention at the beginning, and rightly so, with any kind of a bill I like to see it in rather plain language so I can understand it. Some of us are not privileged, like some of my colleagues, to be lawyers, who speak in different languages I don't understand. Since these things are made for lay people—if you want to call them that—they should be understood. So I welcome that comment you made.

You also mentioned the fact that there were many amendments to these and you welcome those amendments. The last point you made, that you hope these things are passed rather quickly. Don't you think that since the essence of the bill has changed dramatically because of the 200 amendments, one has to look rather carefully to see, as it changes, that we have a bill—which I think is needed so badly—that we go through it rather carefully? I know it's so long awaited.

**Mr Campbell:** Perhaps I should change the word "quickly" to "deliberate speed" or "expeditiously," but clearly not forgoing the time required to study the bill thoughtfully. We support the legislation and support the notion of passing it with due deliberation. But clearly it's better to get it right than to have to come back two or three years from now and make further amendments. So, subject to that, I agree with you: Get it right.

**Mr Mark Morrow (Wentworth East):** I want to thank you for appearing before us today. I have a question about your fourth concern on the harm clause. I'm going to read paragraph 14(2)(c)3 to you: "Whether the benefit the person is expected to obtain from a treatment outweighs the risk of harm to him or her." You say you would change that paragraph. How would you change that?

**Mr Campbell:** Specific language? I'm not really prepared to give you specific language. That's very much the province of legislative counsel and solicitors for the ministry. But our concern is the concept of risk of harm and it might help if members have that section before them. You'll see our point. The whole section deals with the giving of consent on an incapable person's behalf. One of the criteria set out in subsection 14(2), in defining the best interests is, as we look at the next page, "Whether the benefit the person

is expected to obtain from the treatment outweighs the risk of harm to him or her."

What we would like to see is wording either in that section or in a further subsection which suggests that, in appropriate cases, the true harm to the patient is the prolongation of life and treatment in situations which are clearly hopeless or where unnecessary pain or suffering is caused. I defer to Mr Fram or to any other counsel who is knowledgeable in greater detail than I am, but our concern is a decision made in the best interests of the patient should encompass and include a decision not to give treatment in certain circumstances. Our concern is that the word "harm" suggests a value system where death is to be postponed or delayed as long as possible.

**Mr Morrow:** Thank you very much.

**Mr Stephen Owens (Scarborough Centre):** I'm sorry I missed your presentation. However, I did speak quite strongly in support of Mr Sterling's bill some time ago. I believe with all my heart in the process of death with dignity and I outlined some personal experiences with my own family members, as well as volunteering with terminally ill patients, that convinced me even further that death with dignity is the way to proceed.

On one of the issues you've raised, and I guess along with your comments, my concern is that if a person has a living will but presents at the emergency for treatment for a non-related problem, what suggestions would you have for administration so that the wishes of that patient could be honoured in line again with the comments that you've just made?

**Mr Campbell:** That's a very difficult issue because there are many different scenarios which can apply. Let's assume that the person presents at the emergency and he's fully competent and capable of giving instructions to a physician. He might, at the moment of admission and the stage at which where he's receiving treatment, discuss orally what he wants and what sorts of treatment he wishes to have and what sorts of treatment he does not wish to have. The physician, if prudent, would make a note of that and treat accordingly. If the patient is presented in an unconscious state with no one around, assuming an ambulance attendant has brought him in and there's no easy way for a physician to find out the nature of the treatment which he doesn't want to have, then you have a whole different scenario where, under these emergency conditions, the physician should treat and care and maintain or stabilize the patient and then make whatever inquiries are necessary to satisfy himself or herself that the patient is getting the right treatment.

A third scenario would be where the patient presents himself, discusses a course of treatment and then in the course of getting treatment something else arises which he may or may not have contemplated. Again, if he's conscious or unconscious there's a whole range of issues which flows from that. So you have to be quite precise about the facts of the situation which you set out.

If you arrive at an emergency room with your living will in your hand and the living will sets out a number of items or conditions to the giving of care—for example, "I



do not want to be on a resuscitator; I do not want CPR"—and treatment is commenced and for some reason or other the patient has a heart attack or his heart is arrested, then clearly the physician and the patient are in what might be called a terrible bind, because it was never contemplated at the start that the patient would have a cardiac arrest during the course of getting treatment. I doubt very much whether legislation can really cover all of those scenarios. I also doubt very much that the physician would in those situations be authorized to just blindly, without consulting with someone able to give substitute consent, continue a course of treatment never contemplated by the parties. So it's a very, very difficult area.

**Mr Owens:** Just one last comment. In terms of your letter to Mr Sterling, I particularly appreciate the comments you've made in the fifth paragraph on the first page with respect to section 63 and the relationship that should be developed between the guardian, the patient and the family. As part of the death process, it's my experience that this is in fact an invaluable aid to the person who is dying and certainly is a level of comfort to the family and to those who are at or involved with the death of the patient.

**Mr Norman W. Sterling (Carleton):** Had the Ministry of Health or the Attorney General responded to their concern over the ambiguities?

**Mr David Winninger (London South):** Since we don't have the parliamentary assistant to the Minister of Health here, perhaps I'll ask Mr Fram to respond to that.

**Mr Steve Fram:** I've looked at the provisions they referred to and I really don't see an ambiguity. I think where there are expressed wishes a guardian, a substitute decision-maker or an attorney for personal care is bound by section 63 to follow the known wishes. Similarly, with respect to the Consent to Treatment Act, we don't get the best interests unless there is no known wish that's applicable to the circumstances. I think both acts cover the situation where the wish is expressed and clear and you don't get to a situation where you have to apply best interests if the wishes are known.

**Mr Campbell:** May I comment? Our concern may be a narrower one and it is indeed really a technical concern. I must say that the letter which was seen by Mr Fram only a few minutes ago—and so I would request, to be certain, it be run by legislative counsel to see. Our concern was the narrow one. Personal care is defined, treatment is defined and we were a little concerned that "personal care" may not be sufficiently specific to include health care. It's a fairly narrow technical point. I defer to Mr Fram for the time being, but I think it should be followed up by legislative counsel.

**Mr Sterling:** I'm sorry for being late. I was caught up in the Legislature. You mentioned in your letter to me that you're concerned about the complexity of the legislation. Are there any suggestions you can make to the committee—I don't know if you did that before I came in—as to how we could unravel it?

**Mr Campbell:** The complexity in legislation—don't misunderstand this—is more complicated than it seems. There are two aspects of complexity. The first aspect is the complexity of the policy itself and the procedures and the

practices which are set out. The second aspect of complexity is the language which is used to express the policy and procedures. You have to be very careful, when you have a complaint about complexity, to focus on both those issues.

With respect to both of those issues, we do have some concerns. We haven't set them out in detail in our letter because we feel that, complex as it is, it should still proceed in some form or another because there's a clear need that has to be met. But in terms of offering a positive comment, there are three or four levels of complexity I think can be addressed.

There are at least three ministries involved in the administration of this network of statutes, and that itself leads to administrative and other forms of complexity. There will be less incentive, if I can be bold enough to say this, for a particular minister to take responsibility for the whole package. That's perhaps the threshold comment on complexity.

The second issue of complexity is the need to solve the particular problem. The problem I see is that this legislation is going to have to be interpreted by people who are arriving in a hospital setting when there's a fair amount of stress to begin with. It will have to be administered in large part by physicians and health care practitioners also operating under stress, and so it seems to me that you want to have both practices and policies which respond to high-stress situations.

The complexity here is quite profound. For example, in looking at a substitute decision-making scenario you're looking at I think 10 different checklists one must go through to see who could give consent for another, and then five criteria which have to be applied. Think of that in the setting of a confused family possibly speaking a language other than English or French, trying to get a sense from a rushed and harried physician on how they're going to get treatment.

You have the situation where people who are elderly are making decisions in family settings which are quite tense, and here there is a fairly sophisticated legal set of hurdles to overcome.

Our basic view would be to look again at perhaps the Manitoba legislation, which tends to be drafted in a way which seems to me to be a little more easy to understand and seems to set out procedures and policies which are a little simpler.

On the other hand, I must caution—having myself from time to time been involved in legislation—that you cannot make it too simple. In trying to oversimplify you can create 1,001 problems which the judges have to sort out, in which case you're not quite sure where the policy's going to end up. You have a very fine line between making the legislation sufficiently complex but not overly complex. I would certainly look to the Manitoba legislation.

**The Chair:** No further questions or comments? I'd just like to advise you that in your letter to Mr Sterling you asked where you can proceed from here. I realize that time has been short since the amendments have been tabled, so if you do have anything you want to express to the committee, we'd appreciate your sending in a written response any time during the public hearings.

**Ms Seguin:** Thank you very much for allowing us to appear today and to again put forth our point of view. We



do appreciate the legislation and all the work that's gone into it. We're a little anxious for things to happen.

**The Chair:** On behalf of the committee I'd like to thank you for taking the time out today and giving us your presentation.

Just a reminder that legislative research now has the comparison summary of recommendations and the proposed amendments to the bills available and they'll be handed out to the committee members. To allow time for our next presenters to catch their breath when they get here, we'll now recess for 15 minutes.

The committee recessed at 1604.

1621

#### CANADIAN BAR ASSOCIATION—ONTARIO

**The Chair:** I call forward our next presenters, from the Canadian Bar Association. Good afternoon. Just a reminder you'll be allowed a half-hour for your presentation. The committee would appreciate it if you keep your remarks to about 15 or 20 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Mr Paul Milne:** My name is Paul Milne. I'm a member of the committee that was established by the trust and estates section of the Ontario branch of the Canadian Bar Association to examine the property aspects of the proposed Bill 108. Ms Dona Campbell is with me. She is also a member of the executive and was on the committee that examined the personal care aspects of the legislation.

We thought today, to follow the legislation, we would start with the property side first and finish with the personal care side, if that's acceptable to the committee.

After reviewing the proposed amendments, we concluded that it really is a final piece of legislation in the whole map of legislation whereby an individual will be able to plan privately from incapacity through to death and then regulate the actions of executors and trustees. We saw that as a very good thing and wanted to start out our presentation by saying that we really do feel it's a good piece of legislation.

We also believe it's important that the public safety net that's been established be there for protection of the individual grantors, particularly in their incapacity, and it be in effect there at every stage of the process through other legislation.

The concerns we want to talk about today relate to the need to establish a private system that works and is efficient, effective and affordable. The suggestions in our brief relate to these concerns, and I believe you all now have a copy of the brief. It's our belief that the burden on witnesses established by the legislation, especially strangers and staff in professional advisers' offices, must not overwhelm or frighten them. Continuing attorneys and guardians of property must be able to discharge their duties with a reasonable amount of effort; otherwise we're concerned they won't take on the job.

We framed our suggestions in our brief so as to reduce the burden on witnesses and attorneys without, we believe, jeopardizing the safety net protecting the individual grantor. We ask, as we review the points we feel are important, that

you wear the hat of the witness and of a continuing attorney and try to view how you would conduct yourselves in these capacities.

First of all, the matter of subjective and objective standards of care: In our previous submission, we reviewed the concept of authentic decision-making in Bill 108, which required encouragement of participation by the incapacitated person, which we felt was not compatible with the general standard of care imposed upon a substitute decision-maker.

We believe that the objective standard was the appropriate standard, namely, one independent of the perceived desires of the incapacitated person. That's the appropriate standard that should be imposed so that the obligations of the continuing attorney or guardian of property under the legislation would not be so difficult to discharge that individuals would not be willing to accept the position. We are also concerned that the notion of authentic decision-making and consultation will place a time burden on a person acting in the capacity as a continuing attorney or guardian of property.

We previously asked that subsections 32(2) and 32(3) be deleted for these reasons. We note, in your proposed amendments, that you've added to these sections, which remain in legislation, new subsections 32(3.1) and (3.2). Subsection (3.1) requires the attorney to foster regular personal contact between the incapable person and supportive family members and friends of the incapable person. We feel, if you take our earlier comments with the addition of this further requirement, that it will add to the burden that people will be concerned about. These are people who are acting as continuing attorneys.

Subsection 32(3.2) requires the guardian or attorney to consult from time to time with supportive family members and friends of the incapable person from whom the incapable person receives personal care. We believe that is reasonable, because a prudent attorney would do so in any event. We're therefore suggesting, for the reasons I have mentioned, that subsections 32(2) and 32(3) of Bill 108 be deleted, as well as proposed subsection 32(3.1). We have no objection whatsoever to subsection 32(3.2).

As far as the duty of care is concerned, as a group we felt quite strongly, in our previous submission, that this duty should mirror the provisions of the draft Trustee Act. I know you've all been through that. It was our concern that sections in different statutes that deal with the same functional matters should be worded identically to avoid uncertainty and the unnecessary social cost of resolving the uncertainty.

We are also concerned that the point of distinction in Bill 108 is whether or not you receive compensation, which then results in a higher level of duty, while the draft Trustee Act makes the possession by a fiduciary of a relevant level of expertise the point of distinction. We believe strongly that it's not compensation, but expertise for which one should be responsible. Again, to mirror our suggestions previously, we ask that you reconsider subsections 32(4) and 32(5), as we previously requested.

In terms of the matter of witnesses, under the present powers of attorney legislation, as you all know, only the attorney and the spouse of the attorney are excluded from acting as witnesses. We don't have any problem with the



class being extended, as the legislation has, but we ask that you view it from the perspective of obtaining witnesses to sign powers of attorney, which of course is very important. You've increased it to two witnesses—we have no problem with that—but the expansion of the class means that for many of us who are attending in institutions—perhaps many of you have experienced that—the classes are so wide that we're concerned that even the policies of a number of our institutions will now need to be changed.

For example, the policy in a number of hospitals of which the members of our committee are aware is that nurses cannot act as witnesses, but that a designated individual or individuals in the hospital can act as witnesses. The reason for that is fear of suit.

The previous submission suggested that paragraphs 4 and 5 perhaps be deleted. Paragraph 4 relates to employees of a facility where the grantor is a boarder or receives personal care, and paragraph 5 relates to parties to a proceeding to which the grantor is also a party. We also ask that the definition of "relations" not be so widely drawn. It appeared to us that it covered all relations. We saw a great difficulty not only in the problem of mistakes being made with distant relations, but also in the problem of it, again, limiting the available group of people to act as witnesses. It's our feeling that if those classes can be allowed to witness, it will facilitate the signing or the witnessing of powers of attorney. Again, this relates only to individuals.

1630

As to the statements of opinion as to competence, we feel very strongly that those statements should be deleted. I know you've heard this a lot. Our concern is that if there is a problem because of the expansion of the class of persons who can't witness documents, coupled with the need to inquire in the prescribed manner as indicated in the amendments as to competence, we're going to have a very difficult time, especially in urgent situations, finding witnesses.

We canvassed the members of our committee, we talked with other lawyers and we all believe that we really can't ask members of our staff to make these kinds of judgements. Our experience in the past is that generally speaking, professionals have made these judgements and they usually have a standardized set of questions for determining capacity. We believe witnesses will be frightened and perhaps overwhelmed if they have to make some kind of a judgement as to competence or capacity.

We ask that you put your hat on as a witness and consider whether you would be willing, for nothing, as a stranger, to witness a document which has that requirement. If you balance that against the need for the individual, quite often in an emergency, to sign a power of attorney that is going to become a continuing power of attorney, we feel it's appropriate that this statement not be required.

Subordination of other legal obligations: The legislation provides that expenditures necessary to satisfy the incapable person's other legal obligations are not to be subordinated to expenditures needed to support, educate and care for the incapable person and that person's dependants. Again, we feel that is wrong. We are concerned that if subordination occurs, credit may not be available to elderly people if there is some fear of lack of capacity at some

future date. And more important, we still believe that if a creditor moves, obtains judgement and levies execution under the Execution Act, the whole import of that section will be defeated in any event. We ask that you give that further consideration.

As to authorized expenditures for gifts, loans or charitable gifts, again, I'd like to bring you back to the burdens placed on attorneys and continuing attorneys and guardians. Bill 108 authorizes expenditures for gifts, loans or charitable gifts only if the property of the person will remain more than sufficient to satisfy the requirements of support of the incapable person and his or her dependants and of legal obligations.

We asked before that the word "will" be dropped and "reasonably probable" be the words that are inserted in place of "will." Frankly, we don't see how an attorney or guardian can make a judgement literally for all time that the property will be satisfactory for these purposes. We believe they will be forced in many cases simply not to make the gift, loan or charitable gift.

As to protection of innocent third parties, section 37 has been deleted, which we commented on. We suggested expansion of that section and development of a sheltering technique. Again, we tried to view our comments today from a practical nature. All of us on our committee have experienced time and again the concern of, in particular, banks and others on their protection when acting under a power of attorney. We ask that you give consideration to the sheltering technique we proposed previously, as we believe it's workable.

Concerning the matter of powers of guardians to complete property transactions after termination of guardianship, we believed previously, and we believe now, that they were ill-conceived powers. For this reason, our system works well. When death occurs, personal representatives have the right and power to represent the estate or to act on behalf of the deceased's estate.

Quite often that may mean questioning transactions which were commenced before death and not completed because of changed circumstances. If you allow a continuing attorney, for example, to complete those transactions, we see the possibility of conflict. Our system works and we believe it's important that the right and power of a continuing attorney or guardian of property cease on death.

We'd like you also today to consider the possibility of multiple continuing powers of attorney. When we read the new proposed sections 10.1, clause 11(1)(a) and clause 11(1)(c.1), along with clause 11(1)(d) of Bill 108, we concluded that the combination of those sections prohibits multiple continuing attorneys. I will say to you that we're all learning how to use powers of attorney more effectively and the practice varies widely, but we see the legislation as being very important to the development for estate planning purposes and succession purposes, and I'd like to give you some examples.

In a medical office, a medical doctor will very often give a power of attorney to an associate and will appoint that associate as a special executor only for the purpose of maintaining and sale of the practice. Another power of attorney will be given to the doctor's spouse and the



spouse will generally be appointed as executor. That is one planning tool for someone with a licence that can't be transferred to a spouse.

If we have multiple continuing powers of attorney, and that's when these powers of attorney are used in one's incapacity, it will allow that planning technique to continue.

One of the other lawyers on the committee gave an example of a continuing power of attorney for literary purposes where one has a literary agent. Another lawyer has traditionally been concerned about the phrase many lawyers use in a power of attorney, that a substitute comes into place upon death of the attorney or such things as that person becoming incapable. Some, instead of getting into that problem, simply prepare a secondary power in favour of the children.

For those reasons, we ask that multiple continuing powers of attorney be allowed in this legislation, and we direct you to subsections 17(8) and 24(5). This isn't in our submission to you, but for example, in subsection 17(8) of Bill 108, "The public guardian and trustee may certify that two or more applicants are joint statutory guardians of property, or that each of them is guardian for a specific part of the property." So the legislation really already does contemplate appointments for specific types of property.

As far as the replacement of the public guardian and trustee by family members is concerned, we understand your point and we really don't disagree with it as long as we, and I think the members of the public, are assured that the office of the public guardian and trustee will be well funded so the vetting of the suitability of the family can occur quickly. In one's incapacity, you need to be able to act quickly in the majority of times.

If that assurance for whatever reason is not available, we ask that it be reversed in accordance with our previous submission, namely, that they initially be deemed to be suitable, again with the public guardian and trustee having the right and entitlement to determine that a family is unsuitable. We also ask that the same rule apply to a nominee of the family.

Finally, the application of subsection 31(1.1) to attorneys: Right now the subsection refers to property of "an incapable person," and it's a requirement to provide information and deliver property of a grantor to his or her attorney. We agree with that, and we'd like to suggest that this new proposed amendment be expanded to include attorneys also, so the information and property will be delivered to attorneys.

In conclusion, we'd like you to consider, if you will, what it will be like finding witnesses, what it will be like acting as a continuing attorney or a guardian of property and that you balance that with the needs of the individual who wishes to grant a continuing power of attorney to be able to find witnesses and individuals who will act.

1640

**Mr Sterling:** I realize the time has been relatively short for you to consider the amendments. Are you still considering the legislation or have you pretty well finished your analysis of the amendments?

**Mr Milne:** We've pretty well finished, because we believed this was the last opportunity to speak with you.

**Mr Sterling:** So you're focusing on the witness at this point. Is it felt that these protections are absolutely necessary? The one he is talking about, for instance, the staff of an institution: I believe they're excluded by subsection 10(2) from being a witness of a power of attorney at this time.

**Mr Winninger:** The short answer is that we feel these protections are required. I was going to put some questions to the witness myself, but—

**Mr Sterling:** You go ahead.

**Mr Winninger:** I think your concern expressed first of all with regard to subsections 32(2) and (3) and the new subsections that were added really is one of judgement of value. I think the government felt it was more important that incapable people be involved in the guardian's decision-making than to say, "Well, it's going to mean added cost; it's going to mean added inconvenience to the guardian." I guess you and we will have to disagree on that particular issue.

With regard to your concern about section 10 and the witness having to make a declaration of competence, I'm advised by Mr Fram that the kind of declaration that's been made is simply one whereby the witness indicates whether there was something to indicate lack of competence. There's a presumption that the donor of the power of attorney has competence, but if something struck the witness at the time that would indicate otherwise, then that witness would have to so declare. That formality, we feel, is an important one to ensure that only competent donors are granting powers of attorney.

I know we don't have time to deal with all the points and we might be able to talk later, but the other point you made about paragraph 39(4)1 in regard to charitable gifts—at first I found your submission persuasive, but in discussing it with Mr Fram, I'm convinced that we want to ensure the ultimate degree of caution on the part of the guardian here. If there's a shred of doubt that there won't be enough in the fund to look after the incapable person, then that guardian has to assume the charitable gifts can't be made. If we were to go your route and include the words "reasonably probable," it would create a lot of uncertainty. We feel it's far better for the sake of certainty and preservation of the fund that even if there's a shred of doubt, the guardian will avoid paying charitable gifts.

**Mr Milne:** We weren't sure of your perspective in that regard because we felt the same way. We felt that in the vast majority of cases there would be a shred of doubt so there wouldn't be charitable gifts being made. If that's your perspective for the legislation, then I understand it. We felt your perspective, perhaps, was not that strong because of the other sections. Is it possible to ask you a few questions about the matter of the competence?

**Mr Winninger:** I would just indicate one other point: that we'll look at the issue of whether these earlier sections and subsections in combination might work against the existence of multiple continuing powers of attorney. Because we've just received your submissions, we haven't been able to reach any conclusion on that.

**Mr Milne:** We appreciate that.

**Mr Winninger:** I guess I'm in the hands of the Chair as to how he wants to deal with it.



**The Chair:** If Mr Fram would like to respond.

**Mr Fram:** Sure.

**Mr Sterling:** Before the question, I think Mr Milne had a question about the competence.

**Mr Milne:** With witnesses, whether you reverse it, Mr Fram, or whether you leave it in its present format—I can tell you my own experience, and perhaps members of the committee have had a different experience. The members of our committee all had the same experience in that asking anyone to simply witness a power of attorney, if he or she is a stranger—and I outlined to you the rules we know of in some institutions—is quite a traumatic event, and all the person is doing is witnessing a signature.

As we now move into the new scheme, it was our belief that we all concluded we couldn't ask members of our staff to do it. We don't hire them to make those judgements or, in reverse, to watch for something that might indicate incompetence, because then they'll have to make personal decisions based on your prescribed manner or on their own experience as to it. We see it as a very serious matter.

**Mr Fram:** We—this went back to the advisory committee—found, especially with property, that the most concern was about having capacity at the point of granting the power. The committee explored everything from having a lawyer's statement and a physician's examination, and in the end we concluded that the simplest method really does impose obligations on a witness. We hope to make the obligations simpler by putting some questions in the form of a procedure to evoke the yes or no, but again, it's important to filter out—that's why the list of people who are excluded is quite lengthy, and it's a matter of judgement. Every government will draw that line somewhere else. That's where the committee drew the line, and the government accepted the committee's line at that point.

We're going, as you said, from a point where anybody but the attorney or the attorney's spouse can be a witness—one witness required, no statement—and we've seen, if you talk to the Advocacy Centre for the Elderly or to the public trustee's office, the problems that creates. Maybe we don't solve them, but that's the way we attempted to address it.

**Mr Sterling:** Having practised law for a period of time before I got here, there's a real, practical problem here in that you're going to cause a significant amount of increase in terms of the price it's going to cost to have a power of attorney drawn, because you're going to have to get somebody from outside, I presume.

**Mr Milne:** Our belief is that we're going to have to take another lawyer—to use my occupation as an example—in our office to a home or to a hospital, whatever, to sign him, because right now it's very difficult to get a witness under the current regime. We don't believe we'll be able to get people to witness under the proposal.

**Mr Fram:** In the easiest case you'll get the neighbours. Where people have lived in the same place for the same time and exhibit the same behaviour, you'll get the neighbours to witness.

**Mr Sterling:** That's the easiest case, but there are lots and lots of other cases as well.

**Mr Fram:** In the most difficult case you'll get an assessment to satisfy the witnesses. You'll have a capacity assessment where there is doubt. That's done today, in those kinds of cases, by prudent practitioners.

**Mr Winner:** I think you admit, though, that there has been some difficulty in the past and at present. I can remember trying to get nurses to witness powers of attorney, and it was like pulling teeth.

**Mr Sterling:** You're substantiating his objection.

**Mr Winner:** No, what I'm saying is that if it was difficult before, it's not going to change things that much.

**Mr Sterling:** Oh, no, he's saying that it is. You may have cajoled a nurse into doing it before, but that's going to be impossible now. The nurse is excluded.

1650

**Mr Winner:** It's just an extra step, that's all.

**Mr Sterling:** Well, an extra step which is going to double the cost of doing business for the citizens of Ontario to have it done.

**Mr Winner:** You don't know that, do you?

**The Chair:** Further questions or comments?

**Mr Curling:** Am I understanding then that you're saying you identify that there's a problem in the requirement of a witness, and although you are identifying that, there is nothing you can do about it, while it is pointed out that it is difficult to get a witness because of the requirements? Isn't this now the time to sort of make it, I don't want to say "simpler," but make it more practical for someone to require a witness?

**Mr Winner:** Perhaps I could ask, since we're asking you questions now, what percentage of powers of attorney are executed at your office as opposed to a nursing home or a residence.

**Mr Milne:** I would say—I'm just guessing—maybe 70%, because most people now sign them when they prepare a will. It's part of that process.

**Mr Winner:** Exactly. So it's a problem, but it's not an We find the criteria for triggering a finding of incapacity under this bill quite troubling. Section 46 would find a person incapable of personal care if that person is unable to understand information concerning health care, nutrition, shelter, clothing, hygiene, safety. It is our view that the inclusion of subjective criteria such as nutrition, clothing and hygiene evidences a failure to tolerate and respect different standards that are exhibited by different individuals in our society, and we are very concerned that these particular criteria could permit unnecessary intrusion on the rights of individuals.

Furthermore, we're concerned as to the standard for determining capacity under Bill 108. Now, under the Mental Incompetency Act, incompetence must be proven beyond a reasonable doubt, but that act is going to be repealed by Bill 110. Because there is no standard of proof in 108, incapacity will now be established on a balance of probabilities. While this may be sufficient in an acute care situation, we really question whether a balance of probabilities is an appropriate standard for imposing a substitute decision-maker for the long term.



We also remain concerned as to the complex requirements for creating or revoking a power of attorney for personal care. Further complexities have been introduced by the amendments, rendering the involvement of a lawyer almost unavoidable. It is our view that the appointment of a proxy for health care decisions should be encouraged by a simple procedure, far simpler than that set out in the bill, one easily understood by the public. While the involvement of a physician might be appropriate in drafting these documents, it should not be necessary to resort to a lawyer to ensure that the documents are properly completed.

Minor irregularities appear to render these powers invalid altogether. In our view, it would be preferable if the power is assumed to be effective unless proven to be defective. That is, we feel that minor irregularities should only render the power voidable, not void in the first instance.

Something we didn't address in the written submission was new section 50.2. Section 50.2 relates to the effective date of the resignation of an attorney who has acted under a power of attorney for personal care. Resignation will not be effective until written notice has been given to specified persons, that is, to the grantor, to other attorneys named under the power, to any substitute and to the public guardian and trustee if the power is validated or has been accepted for registration under section 50. We question why resignation has been made so difficult for these attorneys.

We note the registration process introduced by new section 50, which has been referred to as the Ulysses clause. We understand that this provision was introduced in response to concerns expressed by psychiatric patients, that decisions made by them while capable be enforceable as expeditiously as possible during a period of incapacity. In our written submission we set out specific concerns we have as to the implementation of that section.

I would now like to look at Bill 109, which is the Consent to Treatment Act. The first version of that draft legislation provided that there could be no treatment without a valid consent, but this language has been changed and a new duty has been introduced requiring the health practitioner to ensure that no treatment is given until an appropriate decision-maker has been found. We question the appropriateness of imposing this kind of watchdog duty on any health practitioner.

We further note that it is not at all clear who the health practitioner is going to be for purposes of this act. The provisions appear to ignore the fact that many practitioners could be involved in the care of any one given patient. Which one is going to bear the burden of this supervision? Furthermore, in many cases, particularly in an emergency situation, a consultant will be brought in to make the diagnosis, hence proposing the treatment, and will thereafter have no involvement whatsoever in the treatment of that patient. Is it really appropriate that this practitioner bear the responsibility of ensuring that no other person perform treatment?

We have concerns also regarding a return to capacity by a patient. Normally such a patient would simply resume decision-making on his or her own behalf, but this is not the case if a guardian has been appointed under the Substitute Decisions Act or if the attorney is acting under a validated power.

Consider the example of a comatose patient who simply wakes up. If a health practitioner has determined that this patient is again capable, why shouldn't the patient resume making health care decisions, regardless of the existence of a guardian or a validated power?

We are still very concerned about a health practitioner's protection from liability. A standard of good faith is applied to the acts of the public guardian and trustee and all other substitute decision-makers. However, in order for a health practitioner to be protected from liability, he or she must have reasonable grounds for believing the consent to treatment or the refusal to consent upon which he or she is relying is sufficient.

Why is a standard of good faith not sufficient also for the health practitioner? We're very concerned that the very imposition of a different standard for health practitioners will make health care unnecessarily adversarial, that it will invite litigation to determine what is reasonable in particular circumstances.

**The Chair:** Any comments or questions?

**Mr Sterling:** Ms Campbell, before you go, do you have anything you would like to get clarified in the amendments from the Attorney General's people in terms of intent or anything like that?

**Ms Campbell:** We were rather confused about section 50, which is the Ulysses clause, but having read the excerpts of comments, I think it was by Steve Fram, we understood why it was introduced but we don't think it's limited in that way. We in fact endorse the Ulysses clause, but we think it may have much broader application and we were somewhat concerned by that, but I did address that in the written submission.

**The Chair:** Any further comments or questions?

**Mr Sterling:** I'd really like to thank the Canadian Bar Association for putting so much work into both the presentations. I really appreciate it.

**Ms Campbell:** I did have one comment.

**The Chair:** Go ahead.

**Ms Campbell:** I wanted to bring to your attention the provisions for living wills that the public is so interested in. We've noted before in other submissions that one of the maritime provinces has a bill regarding living wills that's one page long. Manitoba has introduced draft legislation in this respect. Their legislation is again very simple and very short. The very length of Bill 108 concerns us very much because people just won't understand it, and it's our concern that that means they won't do it, but they want it.

**Mr Sterling:** I could have said those words myself.

**Mr Winner:** I think Mr Sterling was very impressed with what the government tabled, though. He did say that at one point.

**Mr Sterling:** At one point, yes.

**The Chair:** Any more comments or questions? Seeing none, I want to thank you very much for appearing before us today. Seeing no further business before us, we are now adjourned till the call of the Chair.

The committee adjourned at 1703.





## CONTENTS

Tuesday 23 June 1992

<b>Advocacy Act, 1992, and companion legislation</b> . . . . .	J-63
Dying with Dignity . . . . .	J-63
Marilynne Seguin, executive director	
Martin Campbell, legal counsel	
Nancy Mills, director	
Canadian Bar Association—Ontario . . . . .	J-66
Paul Milne, member, committee on Bill 108	
Dona Campbell, member, committee on Bill 108	

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### **Substitutions / Membres remplaçants:**

- \*O'Connor, Larry (Durham-York, ND) for Mr Wessinger
- \*Owens, Stephen (Scarborough Centre ND) for Ms Akande

\*In attendance / présents

### **Also taking part / Autres participants et participantes:**

- Sterling, Norman W. (Carleton PC)
- Fram, Steve, counsel, Ministry of the Attorney General

**Clerk / Greffière:** Freedman, Lisa

**Staff / Personnel:** Swift, Susan, research officer, Legislative Research Service



## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Wednesday 5 August 1992

### Standing committee on administration of justice

Advocacy Act, 1992,  
and companion legislation

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Mercredi 5 août 1992

### Comité permanent de l'administration de la justice

Loi de 1992 sur l'intervention  
et les projets de loi  
qui l'accompagnent



Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
Greffière : Lisa Freedman





### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

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### **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

### **Renseignements sur l'index**

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Wednesday 5 August 1992

The committee met at 1033 in committee room 1.

### ADVOCACY ACT, 1992, AND COMPANION LEGISLATION LOI DE 1992 SUR L'INTERVENTION ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervenants en faveur des personnes vulnérables; Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne; Bill 109, An Act respecting Consent to Treatment / Loi concernant le consentement au traitement; and Bill 110, An Act to amend certain Statutes of Ontario consequent upon the enactment of the Consent to Treatment Act, 1992 and the Substitute Decisions Act, 1992 / Loi modifiant certaines lois de l'Ontario par suite de l'adoption de la Loi de 1992 sur le consentement au traitement et de la Loi de 1992 sur la prise de décisions au nom d'autrui.

**The Chair (Mr Mike Cooper):** I'd like to call this meeting of the standing committee on administration of justice to order. We'll be continuing on the second round of public hearings on the amendments to the advocacy package.

I have a couple of announcements. There has been a package handed out with some of the briefs of people who won't be appearing for all members to read. A reminder that we are on camera in-house only for these meetings: The camera is stationary and won't move at all, just so everybody knows.

### ONTARIO ASSOCIATION OF PROFESSIONAL SOCIAL WORKERS

**The Chair:** I'd like to call forward our first presenters from the Ontario Association of Professional Social Workers. Good morning. Just a reminder that you'll be allowed a half hour for your presentation: The committee members would appreciate it if you keep your comments to about 15 minutes to allow time for questions and comments afterwards. As soon as you're comfortable, could you please identify yourselves for the record and then proceed.

**Ms Susan Roher:** I will begin as chairperson of the OAPSW task force on these bills. I'm Susan Roher. With me today presenting are Ms Doris Baker and Mrs Carol Eisenberg. I trust you all have a copy of our presentation. We will pretty well read through it as quickly as we can.

Let me begin on page 2, reminding you that our original presentation was on February 17. We're happy to go on to say that our association has demonstrated that the social

work profession can make a significant contribution to the drafting and implementation of these important pieces of legislation. Throughout the history of our profession, social workers have advocated for the vulnerable adult, facilitated the voice of the disfranchised and empowered the decision-making of consumers. Central to the practice of professional social work is the involvement of the consumer.

On to the next page: We again would like to mention our support of Bill 74 in its sanction of advocacy on an individual and systemic basis.

In reviewing the amendments, we'd like to recommend the following:

As previously, the question of who decides who is vulnerable has not been addressed in the legislation. We looked for that and couldn't find it.

Moving on to clause 13(1)(b) on advisory committee appointments, we feel there should be specific criteria by which the three other persons appointed by the minister would be selected so as to ensure that those with appropriate training, experience and interest are considered.

I refer now to section 15.2 addressing the relationship of the advocate with family and friends. It reflects our previous recommendation "that advocacy efforts be mediative and non-adversarial wherever feasible in order to promote and strengthen the appropriate care-giving behaviours of the social/family support system and to maintain these systems." While section 15.3 links the advocate with substitute decision-makers, the appropriate linkage and deciding in terms of specific issues should be clarified to prevent conflicting directions.

I refer you now to subsections 30(4) and 30(5). We find these permissive and general, requiring subjective judgements by an advocate in areas where the gradations of harm require detailed interpretation.

Subsection 34.1(3) recognizes that advocacy services are regularly performed by others such as social workers.

Subsection 35(2) should specify disciplinary conditions governing all advocates, especially when dual accountability exists.

**Ms Doris Baker:** I'm Doris Baker and I have some comments about the Substitute Decisions Act. OAPSW is a provincial organization that continues to be in agreement with the principles of Bill 108 of allowing capable persons to determine future treatment decisions should they become incapable. We further support this proposed legislation that's aimed to protect vulnerable adults from financial exploitation, physical abuse or neglect, but we would ask the committee to consider the following comments in relation to these proposed amendments.

Looking at subsection 10(3), we wonder if the witness is required to raise all the questions as raised in subsection 8(1) separately from the original assessment. If this is so, it would appear to be unnecessary repetition and this section,



we suggest, could benefit from some clarification. We would raise similar concerns in relation to subsection 48(3), the criteria under personal consent.

We're pleased to see the issue of non-Ontario guardians is addressed in subsection 17(5) pertaining to property, but it's not apparent with reference to personal care.

Given the multi-assessment requirements of section 46, we recommend that the expertise of professional social workers be acknowledged and utilized as assessors for that section. We continue to support the notion of multiprofessional assessments.

The notion of certificates for substitute decision-makers we think is very significant for expediting services, but we would ask you to have concern that they be produced in some manner that would defy alteration, maybe like a health card or some such thing.

1040

**Mrs Carol Eisenberg:** I am Carol Eisenberg, speaking to Bill 109, the Consent to Treatment Act. OAPSW strongly endorses the important principle of individual self-determination, which underpins the Consent to Treatment Act. We also recognize the advantages of consolidating all consent-to-treatment legislation within the one act.

Social workers, as part of their professional ethics, respect the right of individuals to determine their own future within the values and resources available in society. Additionally, it is important to be able to enshrine in legislation a method for having one's decisions respected in the event one is not able to exercise such decisions at the time they are required.

In addition, OAPSW would also recommend the following: As in our previous submission, our major concern remains that the profession of social work is not included in this legislation. This omission is due to the fact that there is no social work legislation in this province.

Furthermore, in support of the need for legislation, we submit that the assessments and interventions of social workers in health care services require the expressed consent of patients. For example, in discharge planning, the consent of the patient, or patient-client, is key to the effectiveness of the plan, especially when the treatment plan includes transfer of the patient to a nursing home or other long-term care facility. Such plans should not be made without the expressed consent of the patients or their representatives.

**Ms Baker:** We would be happy to respond to any questions.

**Mrs Barbara Sullivan (Halton Centre):** I want to refer back to the first section of your presentation, relating to Bill 74. I wonder if you could clarify your comments relating to section 15.3 which says while the section "links the advocate with substitute decision-makers, the appropriate linkage and deciding in terms of specific issues should be clarified to prevent conflicting directions." Could you clarify what you mean by that, because it seems to me that one of the themes through the entire Advocacy Act is that the advocates are not to make decisions and provide directions on their own account and that it's either the person involved or the substitute decision-maker who is to do that?

**Ms Roher:** As we reviewed it, I don't think we were necessarily referring to the advocate being the deciding vote, but rather to the potential confusion that might exist if there's a conflicting viewpoint between the substitute decision-maker for property and the substitute decision-making person for care, in that they're interwoven, as you can appreciate. Where is the final say should a conflict arise?

**Mrs Sullivan:** You suggest that subsections 30(4) and (5) should be less subjective. Could you expand on that point? This relates to the disclosure of information.

**Ms Roher:** I'm not sure the extent to which I can illustrate our point, except to point out to you that harm can be interpreted in various ways, and indeed there are gradations of harm, some of which could be subjectively viewed and perhaps overlooked or overemphasized. We are searching for a little more clarity and detail of what is meant by serious harm.

**Mrs Sullivan:** One of the things that has been interesting to us as we've been going through the hearings is in fact the conflict between what may be considered a medical determination of serious harm or risk, whether it's physical or mental, and the concerns that the advocate may in fact act as almost a busybody and make decisions about risk to the person involved that in fact don't have merit on a medical basis.

I'm wondering if that's a kind of issue that you're looking at in bringing this forward. I think of restraint; by example, if a social worker or another advocate fundamentally opposed restraints, even though in certain cases there are reasons for those restraints, if that's the kind of decision that you are referring to here.

**Ms Roher:** We hadn't specified it in terms of restraint, but certainly that is a consideration, what does constitute serious harm and what is the extent of risk to the person.

**Mrs Sullivan:** My last question is a more general one relating to the involvement of social workers in the whole system here. Is it your view that social workers should in fact be part of the group that is allowed to make assessments of whether a person is vulnerable, and on what basis would social workers participate in that system?

**Ms Baker:** Yes, we believe that social workers have the education, training, experience, practice and wisdom, and we're frequently called upon. It just happens that the three of us who are before you this morning all work in acute care settings, while we have experience in other positions prior to the present appointments we hold. Frequently social workers are called upon to make those decisions and determinations, particularly when we look at section 46, which lists the six different criteria that I'm sure you're more than familiar with at this point.

In terms of home visits and making judgement calls, it's very important to understand any particular cultural background, any particular mannerisms that a person might have, so that the person who is an eccentric is allowed to continue as an eccentric and not be kind of bound by some other type of situation. Obviously, we believe social workers with psychosocial training are significant persons to be involved in those determinations, but again we believe there should be multiprofessional assessments.



**Mrs Eisenberg:** I would like to add to that, just to say that social workers have been accustomed for generations to operating within a legal framework. For example, it's social workers who implement the Child and Family Services Act through the children's aid societies in Ontario, so they're accustomed to relating social and psychosocial findings and assessments to what the law requires and to operating within a legislative framework. I would just like to add that point as well.

**Mr Norman W. Sterling (Carleton):** I have a specific question with regard to the Substitute Decisions Act. You noted that the issue of non-Ontario guardians is addressed in relation to property. In other words, if you make a power of attorney with regard to a non-resident, then often you have to post a bond or whatever it is. That's the case in appointing an executor of an estate. Do you think it's appropriate that you have that kind of clause with regard to personal care decisions, or do you think that limitation is necessary?

1050

**Ms Baker:** I think it would advance the legislation. Again, under the property one, there's an opportunity there that security doesn't have to be posted if the court makes that decision. Later on, the back part of the legislation—I've forgotten the number—describes that if an order is made when a person is domiciled in another part of the world outside of Ontario the consent, that authority, for a guardian can come into Ontario.

Looking at that, and again looking at the map of Ontario and the number of boundaries—Manitoba, Quebec, Windsor-Detroit situations—it seems rather unusual that a son might be living in Detroit and have an elderly mother in Windsor and that he could not be the substitute decision-maker for that person and they're in fact 15 minutes apart.

**Mr Sterling:** For personal care you mean?

**Ms Baker:** For personal care.

**Mr Sterling:** My understanding is that he could and that there would be no sanction against him.

**Ms Baker:** If that's in the legislation, I failed to find it. I hope you're right.

**Mr Sterling:** No, but by being silent, is it not saying that? Your preference is that if people live in another jurisdiction they have the right to make a personal care decision on behalf of somebody when they have been given that responsibility.

**Ms Baker:** I think that could be advantageous to the identified vulnerable person.

**Mr Sterling:** I agree with you, but I believe the legislation says it. Perhaps we can have a clarification from the Ministry of the Attorney General.

**The Chair:** The parliamentary assistant isn't present at the moment.

**Mr Paul Wessenger (Simcoe Centre):** Unfortunately counsel from the ministry is not present here either, but the only thing I would offer is my own opinion that there's no restriction on the granting of power of attorney for a person. Of course anyone could be appointed as the power of attorney; that would be clear.

**The Chair:** We will try to mention that before the day's out.

**Mr Sterling:** Perhaps, Mr Chairman, you would be good enough to have the Attorney General write to this particular group as well with that answer to inform them. The other part I wanted to ask about briefly was with regard to the disciplinary actions against an advocate, which I have been very much concerned about. You express that you would like to see some change with regard to section 35. What kind of thoughts did you have on that end of it? I'd like your input on that.

**Ms Roher:** Some brief thoughts: As I recall, in my review I noted that there would be a fine for improper disclosure. I'm wondering about termination, for example, in situations of just cause. Certainly addressing the potential of a fine is important, but is it sufficiently strenuous for this or perhaps other misdemeanours, as it were?

**Mr Sterling:** You see, one of the problems we have is that we're saying these people are to act for vulnerable people. Therefore, in my view, there has to be some method for people who have the interests of a vulnerable person to complain about an advocate's behaviour towards that vulnerable person when somebody else views that he's not acting in the best interests of the vulnerable person.

**Ms Roher:** Yes.

**Mr Sterling:** I find section 35 totally inadequate. All it deals with is the disclosure of information. It does not relate to other behaviour that an advocate might undertake. Is there anything within the framework with which social workers are familiar which controls or deals with discipline within your profession?

**Ms Roher:** Yes, there is.

**Mr Sterling:** Where would we find that?

**Ms Roher:** You might write to our college, the Ontario College of Certified Social Workers. There are rules of conduct etc. There is a discipline committee there as well. There are also very thorough accountability mechanisms established in departments of social work. The supervisory structure is—

**Mr Sterling:** So you have a disciplinary committee for the association. Are you aware of who sits on that disciplinary committee?

**Ms Roher:** Yes, and you can refer to that. I'm not sure whether you want to know names.

**Mr Sterling:** No, not names, but the type of people who are sitting there.

**Ms Roher:** There are social workers and people who are lay to social work. I was going to say people from outside the profession—lay to social work. It is quite a well-developed system.

**Mr Sterling:** Maybe you could write to me and let me know a little bit about that structure. I'd appreciate knowing.

**Ms Roher:** We'd be very happy to do that.

**Ms Baker:** Mr Chairman, can I add one thing for Mr Sterling? Regretfully, belonging to the college of social workers, it's a voluntary organization, so I don't want to miss that opportunity.



**Mr Jim Wilson (Simcoe West):** We will put that in the legislation.

**Ms Baker:** Thank you for mentioning that.

We had wondered about the dual accountability under that section. We draw to your attention that if an advocate is working for the commission there may be more clear accountability than if there is dual accountability. A person who is working for an agency is appointed as an advocate and could be fined and so on. But one of the suggestions we would probably make would be that if that person had a professional body, the professional body be notified for any additional, but there's no suggestion that an advocate would in fact have a professional body.

**Ms Jenny Carter (Peterborough):** I'd like to thank you, first of all, for your global support of Bill 74, and I'd like some clarification on some of the points that you raised in respect of the Advocacy Act. First of all, you said that the definition of "vulnerability" is not adequate. I think we'd agree that the nearest point we come to really going into this is where the people who can be appointed to the advisory committee are listed, the groups that would be providing people to do that.

If you feel that is not a satisfactory summary of what the vulnerable groups might be considered to be, could you tell us how you would expand that? It seems to me that we're never going to have a total 100% definition of all the possible vulnerable groups or how they might be vulnerable, but could you suggest how we could clarify that?

**Ms Roher:** May I pick up on that first? When I made the comment of who decides who is vulnerable, I was referring to an on-the-spot assessment. Mary comes in; she looks a little off. Who makes the determination that indeed she is vulnerable and requires A, B and C? Who has the authority to do that was the point, not the point of who is on the commission.

**Ms Carter:** No, I realize that you weren't focusing on who was on the commission, but that is the nearest we come to listing the groups that a vulnerable person might be a member of, if you like. They might be elderly, schizophrenic or whatever. Do you feel there's anything needs to be added to that? Because I think the ultimate decision, whoever makes it, is going to be to some extent subjective. I don't think we can ever pin it down absolutely.

1100

**Ms Roher:** From what I recall at the moment, I don't have any particular categories to add to that. I guess it's a question of degree of vulnerability and extent of need, which still appear fuzzy to us, and then, on the basis of that, who decides.

**Ms Carter:** And of course by definition, we are saying that some of these people will have been vulnerable in the past and are no longer so, so obviously there is a boundary that they can cross in both directions over time.

**Ms Roher:** Yes. The vulnerability definition is certainly a slightly different issue than the issue of competency, and we just wanted to draw that to your attention. It's left wide open.

**Ms Carter:** People who were theoretically perfectly competent could in fact be exploited in some way, so that they would need to be included in the definition.

**Ms Roher:** Yes, definitely.

**Ms Carter:** You also asked about criteria for the three other people who would be selected by the minister. I wondered if you had suggestions for that.

**Ms Roher:** We didn't come with suggestions, except to reiterate that appropriate training, experience and interest be considered.

**Ms Carter:** But you don't have any suggestions, more detail, as to what appropriate training?

**Ms Roher:** No. It's just that we noticed that they were omitted.

**Ms Carter:** Okay.

**Mr Mark Morrow (Wentworth East):** First, I understand that it's your second time here, so I want to thank you again for taking the time out to appear before us. I have a question about your last point on Bill 108. Does that refer to section 15?

**Ms Baker:** The notion of certificates?

**Mr Morrow:** Yes.

**Ms Baker:** I think that's spoken to in subsections 17(7) and 49(7), where the guardian is given some type of certificate to carry about, and I could see that as being very expeditious when a person went into an emergency room or there was some business to be transacted. The point we're making is that, I suppose, human nature being as it is, one would hope that this certificate could not be duplicated in some manner or altered in some manner.

**Mr Morrow:** Is this what you're referring to when you talk about the authenticity?

**Ms Baker:** Did we use that word? I guess we did. Yes, the authenticity.

**Mr Morrow:** Okay. Thank you very much.

**The Chair:** Thank you, Mr Morrow. Ms Roher, Ms Baker and—

**Mr Alvin Curling (Scarborough North):** Could I just ask one quick question, Mr Chairman? It's important to me and the professional people who are here.

**The Chair:** Brief. No preamble.

**Mr Curling:** In regard to Bill 74, the Advocacy Act, section 6 talks about the criteria for appointment. It reads, "A majority of the members of the commission shall be" persons who are or have been vulnerable persons. Who are vulnerable—I'm dealing with that part of it. Vulnerable people need advocates. How could a person who would be on that board and who is a vulnerable person then make a decision about vulnerable people? Do you have any comment about that? I'll put it this way: Do you understand it the same way I do in subsection 6(1) here?

**Ms Roher:** I haven't reread subsection 6(1), but certainly I have a great respect for the wisdom of vulnerable people to see things in other vulnerable people.

**Mr Curling:** The old act, though, said that because of vulnerable people—we'd have advocates for them.



**Ms Roher:** Yes.

**Mr Curling:** And this vulnerable person will be making decisions about vulnerable people. But who would be the advocate for that vulnerable person sitting on that commission?

**Ms Roher:** I understand what you're saying and I think that's a complication and needs to be sorted out. But certainly I think the active participation of those who have been there is very important.

**The Chair:** Thank you, Mr Curling. Ms Roher, Ms Baker and Ms Eisenberg—

**Mr Sterling:** Just before this group leaves, the late Mr Fram has arrived, and I wonder if perhaps he could answer the question for this group with regard to powers of attorney for personal care and whether non-residents of Ontario can exercise those powers.

**Mr Steve Fram:** Yes. The answer is yes. There's no restriction on someone in Detroit being the attorney for a parent in Windsor.

**The Chair:** Thank you very much for that clarification. Once again, on behalf of the committee, I'd like to thank you for taking the time out today and giving us your presentation.

**Ms Roher:** Certainly we thank you. Your questions were very interesting.

#### MEDICAL ADVISORY COMMITTEE, HOSPITAL FOR SICK CHILDREN

**The Chair:** I'd like to call forward our next presenters from the Hospital for Sick Children. Just a reminder, you will be allowed half an hour for your presentation. The committee would appreciate it if you would keep your comments to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourselves for the record and then proceed.

**Dr Alan Goldbloom:** My name is Alan Goldbloom. I'm here representing the medical advisory committee of the Hospital for Sick Children. I'm accompanied by Dr Françoise Baylis, who is a bioethicist on the staff of the Hospital for Sick Children. We appreciate the opportunity of speaking to you today, and as I mentioned, our brief is on behalf of the medical advisory committee. I hope you will shortly receive a copy of the brief. I think it's being circulated now.

Like our colleagues from the division of adolescent medicine at the hospital, who have already spoken to you, we were very pleased to see the elimination of a specific age of consent to medical treatment in the amendments proposed to Bill 109. Unfortunately, correction of one problem appears to have created several others.

The new bill certainly helps mature, autonomous adolescents who want to give or refuse consent to treatment on their own behalf, and perhaps without parental knowledge. However, the revised bill may have a very negative impact on less mature, non-autonomous adolescents who resist appropriate and necessary treatment which their parents or guardians want them to have. Any members of this committee who are parents will recognize the tremendous variation

in the levels of emotional maturity and development in the young adolescent population. Yet the bill states that all children of 12 years or over, if deemed capable with respect to treatment, may refuse treatment regardless of their level of autonomy, their level of social or emotional maturity or their parents' wishes. The only way that parents can ensure that appropriate treatment is given to such a child is to have the child deemed incapable with respect to treatment by the health provider, in which case the rights adviser process comes into play.

We have grave concerns about the potentially destructive effect of this aspect of the bill on routine child health care, on routine hospital practice and on normal family relationships. In presenting some examples to you today, we hope to show two things:

1. Not every refusal of treatment by a young person is a "healthy expression of autonomy," and objection to medical treatment is a common and expected behaviour of young teens.

2. There are many situations where it is important for parents to be advocates for their children as they mature, over and above the objections of their children, without involving a rights adviser.

We recognize that the intent of the bill was not primarily to supplant the normal role of parents. Unfortunately, the effect of the bill as it is now written is such that it will do just that, and furthermore, will seriously complicate the provision of normal child health care in Ontario. Our concerns are illustrated in the following examples:

**Example 1:** A 12-year-old boy is brought to the emergency department after falling from his bicycle. He's got a broken arm and a deep cut on his face. Furthermore, he is terrified of doctors and hospitals, but is fully lucid and awake. He states that he doesn't want any needles or stitches and refuses to let anyone touch his arm. The doctor explains that the arm needs to be set and that without careful suturing, the facial cuts will leave nasty scars. Neither injury, however, is causing enormous suffering and neither is life threatening. A delay in treatment may produce a less satisfactory result, but will not put him at significant risk.

The parents want appropriate treatment given, but the boy refuses. The physician feels the boy is capable with respect to treatment, even though his decision-making may be immature. The parents think their son would regret his decision in the long term and that he is now refusing treatment as an expression of his anger towards them. It turns out that he's been grounded by his parents a few days earlier and was disobeying them when he went out on his bicycle.

#### 1110

In this situation, the emergency room physician could not treat the child unless he found him incapable, in which case the following steps would have to take place: The physician would have to notify the child of his entitlement to a rights adviser; the child would then meet the rights adviser and either the child declines to challenge the finding of incapacity or the child challenges the finding, goes before the review board and the finding is upheld. The provisions of section 22 on emergency treatment without consent would not apply, since the injuries are not causing



severe suffering and will not put the child at risk of serious bodily harm.

Here we have a situation of a child who is capable but immature. Traditionally, society has expected parents to act on behalf of such children in order to protect their long-term interests. In this case, would society be fulfilling its responsibility to children by allowing them to be permanently and needlessly scarred?

It's one thing to respect the wishes of a competent adult who insists on a foolish choice. However, our society generally accepts that not all children are fully competent, self-determining individuals whose foolish choices must be respected. The concept of capacity with respect to treatment may be appropriate for adults, but seems unworkable in young adolescents. Maturity and autonomy develop gradually in any child. With respect to any treatment, therefore, a child may be capable but immature. During this phase they continue to require the protection of their parents, along with respect for their developing autonomy.

In reality, the above situation is a very frequent occurrence in any emergency room that treats children. Children, including young teenagers, regularly object to treatments that may be painful. In our society, parents, acting as advocates for their children, regularly overrule their children's objections and ensure that appropriate treatment is given.

Example 2: The parents of a 12-year-old girl are desperately concerned because she's failing at school, seems depressed, is running away and staying out overnight and has lost interest in most activities. They fear for her safety and consult their family doctor who refers them to a child psychiatrist. The parents are keen, but the girl says that she won't talk to any psychiatrist. The parents are willing to bring her along whether or not she agrees to talk.

In this case, the family physician recognizes that this girl is somewhat passive and distant, but doesn't feel that she is incapable with respect to treatment. He deems her capable because, in the strictest sense, she understands that there's a problem, she knows what a psychiatrist is and what the purpose of the referral is. She simply doesn't want to participate. Therefore, the child's verbal objection would take priority over the parents' wishes. Referral to the child psychiatrist can't take place.

If the doctor did find the child incapable, or if the family shopped around until they found a physician who would find her incapable, the next step would be to bring in the rights adviser. Quite aside from the delays involved in the process, the effect of bringing in a rights adviser could in itself be quite destructive on the family unit and could significantly affect any subsequent therapeutic process.

This is a typical problem in child psychiatric practice. It's far more common for an adolescent to resist treatment than to agree to it. While you might question the value of a psychiatric consultation in which the identified patient refuses to talk, a child psychiatrist is very frequently required to sit with a sullen, angry and essentially non-verbal adolescent for extended periods of time as a means of ultimately engaging that patient. The adolescent comes to the session because parents expect the adolescent to comply. Furthermore, this is an important time for the adults to be in control and often the absence of control is the root of the

problem. Bill 109 would interfere with normal parental authority and the process of bringing in a rights adviser would simply aggravate the original problem.

In this situation, why would the government want to discourage or usurp the legitimate role of parents as advocates for their children? Part of the treatment in such cases is in fact to empower the parents. The new law would disempower them.

In the third example we have a measles outbreak in a junior high school in Toronto, something that's happened recently, and public health officials determine that 100 students aged 12 to 14 years need booster doses of measles vaccine. Fifteen children refuse and indicate further that they don't want their parents to give permission on their behalf. The public health nurse at the school believes that these children are capable with respect to the treatment. Since they are capable, they can't be immunized and they can't return to school until the outbreak is over. They may in fact be excluded from school for up to two months. Further, they may pose health hazards to others in the community.

There are several confounding issues that come up here. First, under clause 10(4)(b), the health practitioner would have to notify the rights adviser of each child who objected to treatment since these occurred in a place other than a prescribed facility or psychiatric facility. Second, parents are legally liable to ensure that their children are at school. If children can't attend because they refused to be immunized, will the parents be liable? Third, who becomes responsible for the increased public health risk caused by the refusal of these supposedly capable, but immature, young teens?

Even when there's no epidemic or outbreak of communicable disease, the bill poses a problem regarding immunization. At present, parents who object to immunization on religious or other grounds sign an affidavit to this effect in order to ensure that their children may attend school. Will children 12 years of age or older now be given similar authority to sign such documents if they wish to refuse immunization? In other words, will Bill 109 interfere with what is commonly accepted as routine well-child care?

In the final example, a 12-year-old girl has been injured seriously in a motor vehicle accident and is brought to the emergency department. She will need surgery in the next few hours and will also need blood transfusions. The parents state that for religious reasons they cannot permit blood transfusions. The child is unconscious and cannot speak for herself. The parents insist that she has been brought up according to the principles of their religion and that the child herself would not want a transfusion, despite the fact that survival without it is extremely unlikely.

Under section 23.1 of Bill 109, the health practitioner can override the parents' wishes and proceed with life-saving treatment in this situation. At first glance this may seem quite appropriate, until you contrast it with current practice. Under current law, the health practitioner would view the patient as a child in need of protection under the Child and Family Services Act and would call the children's aid society. By taking the child into temporary custody in order to



permit treatment, our society has taken responsibility for the treatment decision.

Under Bill 109, the decision to treat in this case is potentially at the discretion of the individual physician, seriously disempowering the family members. Ironically, the Child and Family Services Act has recently been revised to be more culturally sensitive. Bill 109 would appear to preempt this act, thereby removing a procedural protection for parents whose wishes, interests and beliefs may differ from those of the health practitioner.

As health practitioners who are committed to the health and wellbeing of children, we're deeply concerned that parental responsibility for decision-making regarding their children's health and wellbeing may be inappropriately undermined by Bill 109. We recognize that under existing law there may occasionally be problems where parents make decisions for their autonomous children.

Bill 109 attempts to solve this problem by proposing the opposite extreme, thereby obstructing parental authority to make decisions for their non-autonomous children. Parents will be powerless whether the child is deemed capable or incapable with respect to a treatment. Remember that if the 12-year-old is deemed capable, she may consent to or refuse treatment of her own accord. If she is deemed incapable, she must be notified of her entitlement to a rights adviser. Either way, the parents are excluded and treatment may be delayed.

In addition to the important ethical and societal issues that come into play in all the examples above, we should also note that there are tremendous logistic implications for these procedures. The examples cited are not uncommon ones. Furthermore, there are procedures routinely done in a hospital like ours, such as complex surgery, transplants and treatment of some genetic diseases, which would be difficult for any 12-year-old to fully comprehend.

We already spend enormous amounts of time discussing the implications and risks of such treatments with parents, and even adults often have difficulty understanding the situations well enough to make truly informed decisions. Thus, for some interventions no 12-year-old could ever be considered capable with respect to the treatment. We might be in the situation of needing full-time rights advisers in the hospital for specific interventions.

1120

What can we suggest? We feel the bill as it now stands is ill-conceived with respect to its effect on health care in children. If your purpose is in fact to empower autonomous children, you've already accomplished this with the elimination of the legislated age of consent. If your purpose is also to protect the less mature non-autonomous children, even if over age 12, then you need to allow parents to speak and act in their children's best interests and to allow the children's aid society to protect children when their parents fail to do so. Our province, under the Child and Family Services Act, already has an excellent system for providing such protection.

Bill 109, by failing to account for the gradual and variable development of emotional and intellectual maturity in young adolescents, will in fact increase the risk for many of these children. It will do so by interfering with family

decision-making processes, thereby delaying needed treatment. The process may do irreversible harm to some families, will disrupt even non-controversial medical care and will be a logistical nightmare for practitioners and institutions that routinely care for children. We believe this aspect of the bill is unacceptable and needs major rethinking and revision.

I have added an appendix which I will not read—it lists a few specifics related to paragraphs in the bill—but we'd be happy to discuss or answer any questions.

**Mrs Sullivan:** Everything that comes around goes around, I suppose, because we've been dealing with the age question, I think almost from day one of public hearings on these bills. Providing an authority to children who are capable and mature of certain decisions, and keeping that medical information in a private way and treating the young person as an adult, is frequently in conflict with the best interests of the child in terms of other decisions.

We have already heard from children's aid societies about some of the difficulties associated with these amendments. One of the things I think we're going to want to explore further is whether indeed there should be another section or portion of the bill—and perhaps counsel will be involved in that—that would eliminate the provisions of the bill to the requirements of the Child and Family Services Act. That still leaves parents, however, in a different and difficult position. I think as we proceed we want to explore all these issues further.

You've indicated at some point in your brief that there is a serious conflict between the rights adviser intervention in subsection 10(2) of Bill 109 and the ability of the practitioner to treat with a substitute decision under a different section of the bill. How would you see physicians at Sick Kids' or another hospital determining the priority, and if the legislation proceeds as it is, how would they operate?

**Dr Goldbloom:** I think you've asked a very appropriate question because there's great uncertainty at this point, and you have to see this in the light of the current mood, if you will, in the health professions, which is that people are very fearful of prosecution and very concerned about protecting themselves not just for the immediate decision but also, if they treat a child against that child's wishes and, for example, there is a poor outcome or a child is unhappy five years later, are they going to be sued five years later by a child who says he or she was overruled and didn't have access to the legislated rights in the bill?

I think also this whole issue of determining capability or capacity with respect to treatment is very ambiguous and I'm sure you could get different opinions. When I mentioned that parents might shop around, I think that could happen, but that doesn't help us in the emergency room setting. What we're dealing with in the emergency room are sometimes life-threatening problems where decisions have to be made quickly.

I think the uncertainty has to be resolved. I don't think the intent of the bill was to ever prevent that kind of treatment from taking place—at least from the discussions I've had. Unfortunately, the effect of it may be just that, and that's what we're left to deal with.



**Mrs Sullivan:** In conclusion, I just want to comment on your observation that full-time rights advisers will be required in hospitals. Indeed they will be required in every hospital around the clock and there'll have to be more than one of them. I don't think the cost of that calculation is being taken into account in this legislation at all.

**Mr Sterling:** We've got a bit of a problem here. When we had the previous section 8 in the bill, when people under 16 years of age were presumed to be incapable, the children's aid societies were satisfied with that section. They thought it would take into account the great number of people, and therefore they would be put in a position of authorizing or—I may be using liberty with this language—forcing a young, immature adolescent to take necessary treatment.

We've eliminated section 8 altogether because of a lot of objections from various groups, particularly people who would counsel younger people, particularly younger women with regard to birth control advice and that kind of issue. By taking section 8 out, I assume we go back under the common law in terms of what consent is necessary, what consent you have to get from an individual, and that consent is if you deem that the person understands what's happening. Then the second kicker is that if you find they can't understand, then you've got to call in the advocate, if they're found incapable.

**Dr Goldbloom:** If they're found incapable, but they can still object, if they're over 12, according to the legislation: He may understand, but that 12-year-old can still object, and that objection, at least as I understand it, still takes priority once the child is over 12. That objection means the rights advisory process comes into play, even though the parents may be standing there saying, "Sorry, you're going to have to have this stitched up."

**Dr Françoise Baylis:** If I can add something, I think part of our concern has to do with the reliance on the term "capacity" and the way it's been defined. It's been defined very narrowly. It requires two things, that you be able to understand the information relevant to the decision and that you be able to appreciate foreseeable consequences. That is a relatively low standard. It is perhaps appropriate that you should have such a low standard for an adult, who is presumably an autonomous person who can make choices and weigh up different kinds of considerations. Our concern is that a lot of children can meet that standard, but perhaps have not developed in terms of their own personal maturity to really know which factors they want to base a decision on.

If you think about our example with the measles, if the children understand the relevant information and they understand the consequences, one of the consequences is that they will be out of school for two months. They could base their whole decision on that consequence, choosing to ignore other consequences. We would allow an autonomous adult to make such a choice based on sort of a strange possible consequence. The child, however, doesn't maybe have the maturity, the lifespan and the longer term to think about that, and that's what we're concerned about.

**Mr Sterling:** This is an empowerment process. That's the problem with it. What we're saying is that we want to deal with adults differently than we want to deal with children or adolescents. Quite frankly, I'm empathetic to that thought. I guess my problem is, how do we address it in Bill 109? It's nice to talk about it, but we've got a real problem here.

**Dr Goldbloom:** Well, you do. I think two things. One is that we agree with the empowerment of adolescents. We agree with the fact that adolescents ought to be able to seek out health services, as has been allowed now by the elimination of section 8. We also agree that autonomous, mature adolescents ought to be able to participate in some of the decision-making, and this is a routine for us now, particularly with some of the major treatment decisions that occur in adolescence.

But there is this gradation, and when you say, "How do you deal with it?" maybe we should look at the model that has existed for the last number of years, which is that in terms of protecting vulnerable children, if you will, we expect that parents will do a certain job, and when they fail to do that, we have the Child and Family Services Act, which looks after the child in need of protection. That's the model we've used for children.

Would you be able to accomplish what you're after in adults by modelling something after that? In other words, what you're really trying to do, as I understand it, is to protect the vulnerable adult, the adult in need of protection. The children are already protected. Maybe what there needs to be is an adults' aid society along the lines of a children's aid society, that kind of model, because that's the model that has in fact worked well in jurisdictions all across North America to protect the rights of children when their parents fail to do so. That would maybe be another approach to look at.

1130

**Mr Sterling:** I guess it's nice to say that, but I don't think this government is going to back down with regard to Bill 109 at this stage of the game. What I'm trying to find out from you is, what parts of the equation should we tinker with in order to make your life easier and to make us get a better conclusion for young adolescent people in our society? With capacity? Should we deal with that issue?

**Dr Goldbloom:** As we said in our appendix, the number one thing is section 10, which calls for automatic, indiscriminate involvement of a rights adviser for those 12 and older who are found incapable with respect to treatment. That's where the problem lies. This automatic substitution of a rights adviser for parents in all cases is really the crux of the issue. I think a way has to be found around that, whether it's through the definition of "autonomy" or the addition of the word "autonomy" somehow and some way of defining that or whether it's through the definition of "capacity." But the effect of the legislation, as it is now proposed, is such that it's a terrible problem. Françoise, I don't know if you want to add anything to that in terms of suggestions.

**Dr Baylis:** One of the things I'd like to remind the committee of is that we certainly argued against the legislated age of consent of 16. We know a number of other



people did. Really, one of the things we were objecting to with that was the arbitrariness of any kind of firm demarcation line. Our concern is that you heard us but that you only heard part of the argument, which was to get rid of 16. You didn't understand the part about arbitrariness.

What has happened is that we just have another line that's arbitrary, and what we want to do is to be able to be sensitive to those individuals as individuals and deal with them individually. Some of them need rights advisers; some of them don't. Some of them need to be listened to and respected immediately; some of them don't. We feel the legislation is perhaps faulty in its arbitrariness.

**Mr Stephen Owens (Scarborough Centre):** In terms of your concerns around the determination of capacity, I share a tug on that issue with respect to how you determine whether a person is 12 or 16 in the sort of 15-minute interview that occurs, whether it's in the emergency room or up on the floor. What recommendations would you make with respect to that determination for kids?

**Dr Goldbloom:** I haven't come with a specific recommendation about how you can determine capacity. I think it's a very difficult issue. Whatever happens is going to have to apply to every health practitioner in private offices, in institutions, emergency rooms, wherever. I'm not sure how you're going to be able to decide that other than through defining it in terms of words such as "maturity," "type of treatment" and so forth, which means it will ultimately still be up to the judgement of the individual, and that individual may feel unprotected in making such judgements.

It's easier for us, frankly, in institutions, where we have policies and guidelines and a lot of colleagues we can call in to help us make decisions, than it is for the practitioner working in isolation and having to do that. He may feel quite uncertain.

**Mr Owens:** What do you do now with, say, a 14-year-old leukaemia patient whose disease process has pretty well run its course?

**Dr Goldbloom:** It's interesting you should raise that because that's one of the examples we had discussed. I can present it to you. With a 14-year-old child with leukaemia who's had, say, three relapses of her disease and multiple attempts at chemotherapy, and it's unlikely that anything else is going to do much good, we would certainly involve that child in the decision-making process and the discussions. Our oncologists routinely do that.

**Mr Owens:** Who would ultimately make the decision with respect to her treatment?

**Dr Goldbloom:** We hope that becomes a consensual decision by the parents, the child and the health care providers, and there are a lot of multidisciplinary people who are often called in as part of that process. Those are the kinds of very difficult choices that nevertheless are made on a daily basis at a place like ours, and we fully believe that children ought to be empowered to participate in that.

**Dr Baylis:** I just want to add one comment. Perhaps the most important thing is that in the hospital we work towards consensual decision-making. That's what so much time is spent doing. What we find really difficult is that the minute you bring in a rights adviser, you are introducing

the possibility of an adversarial system and you are in fact condoning an adversarial system where we're going to set up teams and who's going to win. That really is not how we deal with health care and decision-making. We try to get everybody involved.

Where does this rights adviser come in? They come in to say, "Oh, by the way, you have these rights." That's not how we want to have a discussion. We want to try to get know these children, understand how much can these children understand and involve them to the extent that they are able. We don't tie down children and try to force treatment on them. Likewise, we don't ignore them. It's that happy medium we work towards. I'm sure you've heard many other people describe this process as potentially adversarial.

**The Chair:** One brief comment, Mr Kwinter.

**Mr Monte Kwinter (Wilson Heights):** I just want one quick question. It seems to me there are also some economic considerations, that a child may make a decision that may not be life threatening but may impose a severe economic hardship on his family because of the nature of the particular affliction, and for that family not to have a chance to override it or to have some input would seem to me to create some problems. Do you have any thoughts on that?

**Dr Goldbloom:** Certainly, any such decision can have some long-term effects, whether economic or otherwise. I think you just really are restating that same point we're making, which is that it has to be consensual. There has to be involvement of the parents, and 12-year-olds, for the most part, do rely on their parents to help them in those kinds of decisions. But I agree there could be some long-term problems.

**The Chair:** Mr Goldbloom, Miss Baylis, on behalf of this committee, I'd like to thank you for taking the time out this morning and giving us your presentation.

#### YOUTHDALÉ TREATMENT CENTRES LTD

**The Chair:** I'd like to call forward our next presenter from the Youthdale Treatment Centres. Good morning. Just as a reminder, you'll be allowed a half-hour for your presentation. The committee would appreciate it if you'd keep your comments to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Mr Hugh Kelly:** I'm Hugh Kelly, solicitor for Youthdale Treatment Centres Ltd, which is presenting to you today. Dr Jim Deutsch is the director of the crisis unit operated by Youthdale. Mr Paul Allen is the assistant director in charge of administration of the unit.

Mr Chairman, members of the committee, it is our intention not to read this whole brief but to highlight it for you. I will start, Dr Deutsch will discuss some of the clinical implications of the population we serve and, following that, Mr Allen will give you a bit of a view on some of the administrative issues that are involved.

Youthdale is an Ontario corporation operated on a non-profit basis. It has been in existence for 23 years, having been started in 1969. It is probably the most experienced



provider of children's mental health services in the province of Ontario, and perhaps the oldest. It is certainly the largest in Ontario.

Youthdale employs a dedicated and professional staff of psychiatrists, psychologists, physicians and social workers, as well as child care workers, each a specialist in child-oriented problems. Our focus today is on Youthdale's modern eight-bed facility, located in downtown Toronto, which provides emergency secure treatment for children resident from Kingston in the east, Orillia in the north, London in the west. It is the only emergency secure treatment facility operating in Ontario.

Dr Deutsch will describe in a few moments the population that we serve, but I think it's important for you to understand that this facility is invariably at capacity, necessitating all-too-lengthy waiting lists for children in need. This is so, despite the fact that for every application for admission that is granted, five are declined because of the extremely restrictive admission requirements.

1140

I should also point out that in recognition of the success and contribution of its programs, Youthdale has received the prestigious American Psychiatric Association's Hospital and Community Psychiatry Gold Achievement Award. Youthdale staff continue to develop newer and more innovative programs to assist troubled youth and their parents and they are acknowledged as leaders in this growing and clinically demanding field.

Children are admitted to this unit under the Child and Family Services Act under the provisions dealing with emergency secure treatment. We have appended to the brief, starting after page 14, extracts from those provisions, and I'll make some reference to them in a moment.

Children admitted to the program are under the age of 16 years and generally, though not always, over the age of 11 years. They have a substantial disorder of emotional processes, thought or cognition, which grossly impairs their capacity to make reasoned judgements. They have caused, attempted or threatened serious bodily harm, even death, to themselves and/or to others, in circumstances that those responsible for them believe could come to pass unless extraordinary measures and intervention are imposed. They are literally children out of control who require stabilization so that they may be able to continue their progress to adulthood that society can accommodate and in which they themselves can live in reasonably comfortable relationships.

Youthdale's provision of emergency secure treatment is governed by part VI of the act which, as I've indicated, is attached. Under this legislation, Youthdale has been approved by the Ministry of Community and Social Services to operate the secure treatment program, providing effective and appropriate treatment to allow for the admission of mentally disordered children who, as a result of these disorders, have caused or attempted to cause, or by words or conduct have made substantial threat to cause, serious bodily harm to themselves or others. You should be aware that children under 12 are admitted to Youthdale only with ministerial consent.

Youthdale is literally the facility of last resort. Admissions are only made after completion of a very thorough

clinical assessment and only if no less restrictive method of providing appropriate treatment exists. Youthdale is a secure treatment facility; that is, a locked setting offering round-the-clock psychiatric and other medical and nursing services. Treatment, both individual and group, is geared to resolving as rapidly as possible crisis situations for a child and/or his care givers, preventing further harm, with a view to the identification of the underlying problems and making recommendations for the development of long-term care planning. Precautions are taken by Youthdale to prevent children from harming themselves or others but—you should again be aware—with an emphasis upon the active involvement of the child with support in making reasoned choices.

Although the Child and Family Services Act allows for emergency secure treatment for up to 30 days, the average length of stay at Youthdale over the past 10 years during which this service has been provided has been consistently about 14 days.

The emergency secure treatment process at Youthdale is not unregulated. The Child and Family Services Act requires that a child be advised of his or her right to a hearing for a full legal review of the propriety of his or her admission and to have immediate access to the office of child and family service advocacy and to the official guardian to assist in such review.

Whenever a review is requested, the review hearing, conducted by a three-member review board appointed under the Child and Family Services Act, must be completed and a decision must be rendered within five days of the child's application for review. There is no provision for an extension of that deadline. The Child and Family Services Act directs that the child be released from Youthdale if, in the opinion of the review board, the criteria for admission have not been met.

It should be noted that nothing in this extensive review process prevents the administration of necessary treatment to a child while the review board hearing into the propriety of admission is being conducted within this five-day period.

There are obviously two questions that come to mind: Will the requirements of consent or the proof of incapacity to consent pursuant to the Consent to Treatment Act affect the ability to render emergency secure treatment? Second, do the safeguards afforded by the Child and Family Services Act obviate the need of further consent to treatment safeguards?

Youthdale believes the answer to both of these questions is yes. If you review the sections of the Child and Family Services Act dealing with the emergency secure treatment admission and the review process, you will see that there is a high degree of safeguard of the rights of children. I think, putting it very simplistically, the process is due process. The child has every opportunity to challenge the validity of the admission process. You should be aware that of the perhaps 100 to 125 applications that have been made under the Child and Family Services Act for a review of admissions in the past two years, approximately 95% of those have been upheld by the review board after, I can tell you from personal experience, rather exhaustive hearings, some of them lasting up to 12 to 14 hours.



There has been a suggestion put forward that some of the problems related to the addition of the Consent to Treatment Act review process could be solved by cross-appointments; that is, appointees to both the review board under the Child and Family Services Act and the review board under the Consent to Treatment Act be the same persons. That suggestion is, with great respect, too simplistic. It fails to recognize the profound implications of permitting the children to continue to present a risk to themselves and others by reason of the delays that are built into the proposed Consent to Treatment Act.

I draw to your attention that unlike the Child and Family Services Act where a review process must be completed and a decision rendered within five days of the application, there is no such time limit contained in the Consent to Treatment Act. A child out of control is entitled to be protected from the very risks inherent in the delay; similarly, because they are in a group setting, other children are entitled to be protected from the harmful influence of the child who would merely be held in detention without treatment.

We conclude by making some specific suggestions starting on page 11 of our presentation. Perhaps I'd just draw your attention to page 11. There are four alternatives: an exemption of emergency secure treatment facilities from the operation of the Consent to Treatment Act; an enforced 10-day delay in the exercise of the right to seek a review of the finding of incompetence to consent or refuse to consent to treatment where there has been a refusal of an application for release from emergency secure treatment under the Child and Family Services Act; a reinstatement of the presumption of incapacity in the now removed section 8; an expansion of the discretions granted to health practitioners under section 22 of the Consent to Treatment Act to provide increased protection to children admitted to emergency secure treatment such as offered by Youthdale.

The common thread of these is that there is already in place under the Child and Family Services Act an adequate review process that is perhaps on a much shorter—if I may put it this way—leash than that proposed under the Consent to Treatment Act. Again, I emphasize that under the Child and Family Services Act that review process must be concluded and the decision made within five days.

I also draw to your attention that the maximum stay under emergency secure treatment under the Child and Family Services Act is 30 days. It doesn't take much mathematics to realize what could happen with even routine delays if there was provision for two hearings. It is for this reason that the suggestion is made for a delay factor, where there has already been an application under the Child and Family Services Act for a review. What can be foreseen is that a child would run to the end of the 30-day maximum period while the review process is being undertaken. It frustrates the whole point of the emergency secure treatment.

I would now like to turn over the discussion to Dr Deutsch.

1150

**Dr Jim Deutsch:** It would be impossible to discuss in a brief period of time all the joys and sorrows and hopes

and disappointments that are involved in treating this very complicated but very deserving group of kids. I think the problem in the legislation in a nutshell is that it isolates for scrutiny only one aspect of the whole picture.

Children and adolescents need to be listened to very carefully, and that's how we begin with them as soon as they come in our door. We have to work fast and understand them and their situation as quickly and as completely as we can. We do need their cooperation in this process.

Children and parents often have mixed feelings, however, when help and support are offered to them. That's only natural. However, the children and families we serve on an emergency basis are at the end of the spectrum. They're not the average. They're highly disturbed, highly damaged and often highly damaging. It's often quite scary to hear their stories and to work with them when they arrive at our door, but their behaviour can be seen as a reflection of their inner turmoil, as well as a challenge to the adults to take control. Kids sometimes put this into words: "I want you to take control. I want someone to take control. It's too chaotic. It's too crazy."

The legislation, I believe, can undermine the authority or hierarchy, as we use in technical jargon, which is a developmental necessity for the child. We see time and again that children do so much better shortly after they arrive on our unit, and I think part of this is an immediate response to the fact that it's safe. The door is locked, so they can't run, but also the abuser or the threatening or harsh adult cannot just walk into the bedroom. They are also responding to the fact that they know who's in charge and also that there's a very clear expectation of mutual respect. There are rules. Things are made clear; they are not so confusing.

Treatment, I think, is inseparable from residence on the unit, and the process envisioned by the legislation I think would pose us with a dilemma. First, if a child is refusing the treatment, this can be disruptive to the group or the community function which is such an important part of how we work. We work primarily through talking and listening, individually and in groups. We have a school. We have activities. If a child is sitting it out in a separate part of the program or is obviously not taking part, it can be very disruptive in almost a contagious manner to the other kinds.

The second aspect of the dilemma is that we wouldn't be able to offer the service to a child, and this very child would often have a tremendous need for such a service, for reasons of safety, emotional wellbeing and, most important, the opportunity for a positive change in his predicament.

I've been director for four years now. In our experience, some children whose stay with us is terminated early and abruptly for legal reasons under the Child and Family Services Act end up not being followed as closely or cared for as well and as comprehensively after they leave the unit. Hence, they are very much in more danger as a result.

**Mr Paul Allen:** I would only add a few comments. With respect to bill 109, as I understand it, while there is a requirement that the health practitioner advise children 12 years of age and older of their right to a rights adviser and a hearing to review any determination of incapacity, at



Youthdale, under the Child and Family Services Act, we as the health practitioners have been required upon the admission of a child to our program to advise him of his rights to a review of his admission.

In putting into practice the Consent to Treatment Act, we would extend, in our practice at least, a sense of obligation to inform all children, even those under the age of 12, of their rights to meet with an adviser and to have a review of any finding on our part of their incapacity to refuse consent to treatment. It would be impossible for us to do otherwise, given that these children under 12 live for at least a short period of time with children up to the age of 16.

Perhaps I could speak to the relatively few number of children who are admitted to our program who go ahead with a review of their admission to the program, and suggest to you the difference we would find working with that population if we also had to contend with the Consent to Treatment Act.

For the children who do apply for a review of their secured treatment admission, we at least have a number of days to engage that child in the treatment process at Youthdale. We can approach that child with some expectation on behalf of his or her parents or legal guardians that he or she give our program a try, notwithstanding doubts he or she might have about our trustworthiness or the effectiveness of the work we might offer.

What we have found in a significant number of those cases is that we are able to establish a treatment alliance with those children, that there is some level of satisfaction that the child himself or herself experiences even in the first few days of our intervention. I'm very concerned, upon the admission of a child who refuses consent for that treatment, that we are put on hold for the entire duration of the stay of that child. In effect, from the day the child walks in the door, we are faced with a refusal for consent from that child for treatment with a view to a further review of the child's admission. There is no opportunity within the two weeks we set aside on an average for the child's stay in our care for that child and family to receive any real assistance from our program.

As Mr Kelly has eloquently put it, it would effectively reduce what really is a premier treatment resource to a detention centre for children who are very dangerous and who are very seriously mentally disordered.

**Mrs Sullivan:** I want to suggest that there might be two alternatives in solving the problem you face and some of the problems that, by example, the Hospital for Sick Children faced in terms of child treatment. One of them is that the Child and Family Services Act would have statutory precedence over Bill 109. Would that solve your problem?

**Mr Kelly:** In fact probably not, because at the present time, as the legislation now reads, there would be an entitlement to both. If I were acting for a child, it would be a very simple answer. I would bring an application under child and family services review first, because the thought would be I might be successful in getting my client sprung. The lawyers who act for children—I mean this in no critical way—are inclined to think of it as springing their clients. If I lose that, then I can always bring an application for

review under the Consent to Treatment Act and therefore effectively defer treatment until the statutory limit of my stay is up.

This is why we suggest, as we do in the last section of our brief, if I can draw your attention to 5.2 on page 12, that there should not be a prohibition of using the Consent to Treatment Act but a delay, in the event that there has been an application under the Child and Family Services Act, for a 10-day period. This is not uncommon, for example, under the mental health legislation, where you can't bring successive applications for review one following the other. There has to be a time span because the sense is there will be no significant change in circumstances. If that concept were implemented in the Consent to Treatment Act, then that would go a substantial way to avoid the problem we anticipate.

**Mrs Sullivan:** Mr Curling has a question.

**Mr Curling:** I'm trying to understand all this. It seems to me Youthdale is a sanctioned legal body under the Child and Family Services Act. If all this new legislation would empower you to act on their behalf, would that solve the problem? As you said, you then become the full advocate because all the children in your care have either mental or medical problems and need special care. You now become the advocate for these individuals. If this legislation happens, would you then take over that role?

**Mr Kelly:** I don't see that that's feasible. The legislation contemplates that it would be somebody independent of the treatment facility. That only makes good sense.

1200

**Dr Deutsch:** This is ongoing now. We have an advocate who sees the child, usually the same day, within hours, in the child advocacy office, so that's already in place.

**Mr Sterling:** Because these adolescents and children are the severest end of the spectrum, am I correct in assuming that the treatment is in some cases quite severe or dramatic as well? I'm having difficulty understanding. I think the Consent to Treatment Act is an empowerment act and therefore gives the individual the right to make choices. What kind of treatments are we talking about here?

**Dr Deutsch:** That's a very interesting question that you raise. Actually, the healthier kids may exhibit the more disturbing behaviour. The kids who have stayed in their room for the past three months and have had almost no contact, other than accepting the food that's handed to them by a parent who is frightened and doesn't know how to handle the situation and is afraid to seek help, are the children we're most concerned about in terms of the treatment.

The treatment basically in child and adolescent psychiatry is primarily based on talk and group interaction. We do use medication. There are behavioural techniques that are used, but over the years I think the bad reputation that these techniques have earned has become less and less justified because we are now all multidisciplinary in terms of our teamwork and multimodal. We use very many different kinds of techniques. We do use medications. We don't use electroshock therapy. We don't do psychosurgery and we don't have punishments in terms of behavioural modification.



**Mr Sterling:** Good.

**Mr Allen:** Maybe I could answer your question and add to Dr Deutsch's answer. We have many people coming from the United States and from elsewhere in Ontario and Canada to visit our program. If there is a common observation that comes through as they observe the children in the group milieu on our unit, it is the surprise they have that the children with these problems are functioning that well and look so apparently happy with their treatment on the unit.

**Mr Sterling:** As you portray the consent to treatment, it basically is going to impede timely treatment to these people who need it the most. Can I ask the parliamentary assistant for the Minister of Health about the concern? Is the Consent to Treatment Act, for this particular class of citizen that we have in Ontario, intended to be an added protection for them, and do you deem it necessary in terms of the other protections which these individuals have in this kind of a setting?

**Mr Wessinger:** I'd say it's basically a codification of the common law with some modifications. Basically that's what they've done in this act. It's a codification of the common law with some minor modifications, particularly with the question of the age of 12 and rights advice. Other than that, as I said, it's still a common law test with the amendment that's put forward taking away the basis of the age aspect.

**Mr Sterling:** Again to the parliamentary assistant, the witnesses point out that there's a serious impediment to the treatment of these individuals introduced by Bill 109 which can act to the detriment of these individuals. I take their word for it. What is your objection to excluding this kind of institution, or people under the care of this institution, from the application of Bill 109?

**Mr Wessinger:** I'm here today to listen to their concerns. I have some questions myself for the group, which might be interesting.

**The Chair:** Thank you, Mr Sterling. Mr Wilson.

**Mr Sterling:** Just a minute, Mr Chairman, with respect. We're going to go into clause-by-clause hearing of this in the very near future, and I think the clearer we can become as to what your positioning is on individual issues, the less lengthy that process is going to be.

We're gaining some urgency or some alarm with regard to Bill 109 and how it's dealing with treatment of children in particular, or adolescents, and I would like the parliamentary assistant to come back to the committee and express the policy or the reasoning behind wanting to include these people, if there is a reason, because I want to know in terms of my fight with regard to including or excluding this kind of agency. I would really like to know what the reasoning is, if there is sane reasoning.

**Mr Wessinger:** The reason obviously is to ensure that the common law principle of consent exists through all institutions, whether they be psychiatric institutions or otherwise. Then I said if there are some particular problems here, we'll have to take a look at them and see if there are any practical problems that need to be solved.

**Mr Jim Wilson:** Just briefly, I wonder if the witnesses can tell us, have you brought these concerns with respect to what appear to be inconsistencies between the Child and Family Services Act and the Consent to Treatment Act previously to the government and, if so, what was the response? Did you get any assurances by Mr Fram or the parliamentary assistant or anyone that these things would be dealt with? Otherwise, we'd like to know on this side what hurdles we have to help you over in the next little while.

**Mr Kelly:** There was a meeting involving similar kinds of facilities to Youthdale and staff within the Ministry of Health and the Ministry of Community and Social Services but, with no disrespect intended, I don't think our message got through that it is not so much that we are trying to avoid meeting an obligation of due process to these children as how much due process is going to interfere with the ability to provide any service at all.

**Mr Jim Wilson:** That's very helpful. I do have a quick question also with regard to the 10-day breathing period, as it were, between the two review processes. Can you give me a picture of what would occur during that 10 days? My assumption right now is that if the first review process under the Child and Family Services Act said it was an appropriate admission, you would then be able to treat during those 10 days until such time as the individual had access to the consent-to-treatment review process. On whose authority then? On the guardian's or all the other provisions that are provided, and in which act? It's a little confusing for me how you would act during that 10-day breathing period.

**Dr Deutsch:** I think initially we would be carrying out our treatment program, and then it might come to a grinding halt. It's hard for me to picture it as yet, because it hasn't happened on our unit. But as I said before, I think if a child suddenly pulls out and sits on the sidelines and it turns into essentially a detention centre for that one child, it could be quite disruptive to the others, who are always looking for some way to parlay the peer interaction into something more significant and distracting.

**Mr Wessinger:** The first question I'd like to ask the counsel for Youthdale is, are you of the opinion that under the present legislation you can treat a capable child under 16 without that child's consent?

**Mr Kelly:** I think by very definition the child cannot be capable and be admitted. If you look at the definition under the Child and Family Services Act, which is the criterion that they suffer from a mental disorder that affects their ability to reason—I won't go into the definition unless you wish me to.

**Mr Wessinger:** No, that's fine.

**Mr Kelly:** —they are by definition not capable.

**Mr Wessinger:** My second question is that you're under the Child and Family Services Act. On the other hand, adults in psychiatric services are under the Mental Health Act. Is there a difference between the two acts with respect to the powers, for instance, what your facility can do?

Second, would it be preferable if your institution was under the Mental Health Act? It would appear to me



primarily, right now, that if you were under the Mental Health Act, the young people you deal with could be admitted to your institution under that act. I am wondering if there are differences.

**Mr Kelly:** Until April 1989, if I am correct, Youthdale was a psychiatric facility under the Mental Health Act. At that time, by regulation, it was delisted as a psychiatric facility and brought under the Child and Family Services Act. To the best of my recollection, I don't think in the eight years before that conversion was made there was a single application under the Mental Health Act. Since that act has come into force and since Youthdale has been under the Child and Family Services Act—again if my memory serves me correctly—there have been between 120 and 130 applications for review.

**Mr Wessenger:** So what you're saying is there's less opportunity for review under the Mental Health Act than under the Child and Family Services Act.

**Mr Kelly:** I don't think there's less opportunity; I think there is less incentive. Our experience has been that there has been less incentive.

**Mr Wessenger:** Would it solve your problems to a large extent if your facility was under the Mental Health Act?

**Mr Kelly:** I'm not certain I'm capable of answering that in an absolute way. I suspect that the same problems could well affect mental health facilities, in so far as youth are concerned, as we've described under the Child and Family Services Act. Our concern is that because we are a

very narrowly time-limited facility—on average, 14-day stays—the whole 14 days, even if it's expanded to the statutory maximum of 30 days, will be used up in legal process, not in helping these kids.

**Mr Wessenger:** I think that's really the question. If you're under the Mental Health Act, you'd have a longer period of stays. Is that correct?

**Mr Kelly:** I don't think the operation of this unit would change substantially, but perhaps I could ask Dr Deutsch and Mr Allen to comment.

**Dr Deutsch:** We've certainly considered the implication of the switch to the CFSA and what it would be like to switch back, and it's really hard to say. It's an experiment, in a sense, that hasn't been done yet. I think we've continued to operate as a crisis service for children and families, and it's been a rough road at times to maintain that service with the change in legislation. But basically, I would think that a place like Whitby Psychiatric Hospital, which has an adolescent unit, is going to have problems with this as well. I assume that they would be making a presentation around their situation.

**The Chair:** Mr Kelly, Dr Deutsch and Mr Allen, on behalf of this committee I'd like to thank you for taking time out and giving us your presentation today.

This committee now stands recessed until 2 pm this afternoon.

The committee recessed at 1214.

## AFTERNOON SITTING

The committee resumed at 1405.

## BAYCREST CENTRE FOR GERIATRIC CARE

**The Chair:** I call this committee back to order. I'd like to call forward our first presenter from the Baycrest Centre for Geriatric Care. Good afternoon. I remind you that you'll be allowed a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Mr Moshe Greengarten:** My name is Moshe Greengarten. I am vice-president of public affairs for Baycrest Centre for Geriatric Care. I believe you have copies of our submission in front of you, so I'll just highlight and not go through it in detail.

While we remain concerned about certain aspects of the amended bills, we are prepared to support their enactment, although we have made certain recommendations which we hope you will take into consideration.

As we noted in our original brief, we want to emphasize again that this submission is confined to dealing with the elderly and that the concerns we have raised may have little or no bearing with respect to other vulnerable groups.

I want to begin by stating our support for the amendments concerning research in the bills and to commend the government on the appointment of Professor David Weissstub to head an inquiry on non-therapeutic medical procedures on behalf of mentally incapable individuals.

We also wish to endorse the amendments to Bill 109 regarding emergency treatment. In particular we support the amendments to subsection 22(1), which redefine the nature of treatment that may be administered by a health practitioner without consent; subsection 22(3.1), which permits an examination without consent to determine the need for treatment; section 23.1, which permits treatment under certain circumstances in which consent is refused, and the substitution of the term "rights adviser" for "advocate." At the same time, we recommend that Bill 74 be amended to specify the definition, qualifications and responsibilities of rights advisers.

We also support the proposed amendments concerning the assessment of capacity and we have some recommendations that we would ask the government to take into consideration following passage of the legislation regarding training and education for professionals, care givers and the community at large.

With respect to advocacy, we also wish to state our support for many of the proposed amendments. These include clause 1(b)(ii), which identifies the specific circumstances under which advocacy services are to be provided; clause 7(1)(k.2), establishing a written review procedure for dealing with complaints; subsection 7(5), which specifies the various groups for whom public information and education programs will be conducted; section 10, establishing an advisory committee; sections 15.1, 15.2 and

15.3, setting out the responsibilities of the advocate, and we particularly welcome references to family and friends in these sections, and subsections 30(3), (5.1) and (5.2) regarding disclosure of information.

At the same time, we remain concerned about several issues which we would like to bring to your attention.

We're concerned about the amended definition of "vulnerable person" in the Advocacy Act which has been expanded to include a perceived mental or physical disability. We believe it is inappropriate to base advocacy services on perceptions of vulnerability.

We continue to be concerned about the apparently universal nature of the advocacy program and we remain convinced that advocacy services should be targeted to vulnerable individuals who are at risk and who do not have supportive family and friends. We therefore recommend that Bill 74 be amended to require the Advocacy Commission to establish guidelines for the appropriate involvement of the advocate.

We remain concerned about the advocate's rights of entry to care facilities. We feel these remain excessive in the amended legislation. We therefore recommend that the bill be amended to provide rights of entry to health care facilities under the same conditions which are applied to entry to other premises.

With respect to access to records, we are similarly concerned that the advocate's rights of access without the vulnerable person's consent are excessive. Specifically, we believe it is improper to be left to the judgement of the advocate whether the vulnerable person is incapable of giving or refusing consent. We therefore recommend that Bill 74 be amended to give the advocate rights of access to records without consent only if the vulnerable person has been assessed by an assessor as incapable of giving consent.

As already noted, we support the establishment of an advisory committee. At the same time, we believe the mandate of this committee should be set out in legislation and we have some specific recommendations.

Finally, we remain concerned that the membership of the Advocacy Commission, as set out in the amended act, does not allow for representation of certain vulnerable older adults, particularly individuals with Alzheimer's disease, and we therefore recommend that Bill 74 be amended to ensure that groups of vulnerable persons who cannot represent themselves, including individuals with Alzheimer's disease, be represented by family members of such vulnerable persons.

**The Chair:** Thank you very much. Questions and comments.

**Mr Kwinter:** On that last point you just mentioned, we discussed earlier this morning the possibility of having advocates sitting on these boards. Would you have any comments? When you talk about people, particularly with Alzheimer's disease, being represented by family members of such vulnerable persons, what would your reaction be to an advocate of that vulnerable person sitting on that board?



**Mr Greengarten:** That depends on whether you mean an advocate as designated under the legislation or an advocate in the generally accepted definition of the term outside of the legislation. If you mean the specifically designated advocate as defined in the legislation, I think we would take issue with that, because I think that would represent a conflict of interest with respect to the purpose of the Advocacy Commission. If you mean by that the informal advocate, who might be a family member or friend or supportive person, we would certainly support that very strongly in the case of individuals or groups of individuals who cannot represent themselves.

**Mrs Sullivan:** I'd like to pursue some of the issues and will be doing so with other groups and organizations, with respect to assessors and who should be an assessor and how they should be qualified. I note that you have once again reiterated your emphasis in that area. The Ontario Association of Professional Social Workers this morning told us that as part of their work now they are in fact making assessments on a regular basis in terms of competence. I wonder if you'd expand on what you feel should be specifically included in the bill with respect to assessors.

**Mr Greengarten:** I don't feel I can personally respond to the specific request that you're making. We did recommend initially, and continue to recommend, that there needs to be some investigation of the appropriate qualifications of assessors. We were pleased to see the term "physician" removed as an amendment, the automatic assumption that a physician is a qualified assessor. We do believe that many different types of individuals could be assessors, given proper training, and we believe there needs to be study and investigation of that and perhaps some testing of the appropriate qualifications. Beyond that, I would not feel competent to respond to your question.

**Mrs Sullivan:** Are you predicting or expecting that as a result of the implementation of Bill 109, rights advisers will become a part of the staff or operating facility at Baycrest?

**Mr Greengarten:** We honestly don't know exactly what will happen. We are familiar with the model being used in the psychiatric hospitals. We don't know whether such individuals will be available in all institutions or would be our staff or somehow independent of institutions.

Quite honestly, this was something we had suggested in our initial brief, that some of these details be worked out in advance, but we understand there is a desire to move forward on the part of the government with this legislation. We are sensitive to that and we're prepared to work together to try to ensure that an appropriate and helpful system is set up. One of the reasons we did recommend that the advisory committee have specific powers in the legislation was to address these types of issues and to give advice to the Advocacy Commission on these types of matters.

**Mr Jim Wilson:** Thanks very much for your presentation. I read between the lines here that perhaps you're being very kind to the government in that your recommendations aren't all that tough. Am I right to draw the conclu-

sion that really it's inevitable that this legislation is coming in and you're trying to be as helpful as possible in terms of suggesting some amendments to Bill 74? Are all the amendments you've suggested here rated in order of any type of priority?

**Mr Greengarten:** No, they are not.

**Mr Jim Wilson:** They are not. I was wondering in terms of the definition of vulnerable persons and the word "perceived" if that was a basis for any lengthy discussion with your colleagues. It's the first I've heard it discussed here, that's why.

**Mr Greengarten:** It is an amendment to the original definition. I guess I would like to say that we have not been able to exhaustively discuss the potential implications of this, but we have some concern initially that the service is to be based on a perception of vulnerability. We understand that this can be problematic. How does the advocate know the person is vulnerable? How is that established? We have some concern that a person may be perceived as vulnerable and may not be vulnerable, so we have some trouble with that definition.

**Mr Jim Wilson:** It certainly welcomes differences of opinion.

**Mr Greengarten:** It does.

**Mr Jim Wilson:** If you had a wish list, though, is there anything problematic, particularly with the Advocacy Act, that you'd like to point out to the committee?

**Mr Greengarten:** I would say our recommendation 7, because we do remain concerned about what feels like a shotgun approach, although the amendments do provide greater definition, and our recommendation 8, because we continue to be concerned that the act would allow for case-finding or fishing expeditions, and we're concerned about that.

**Mr Jim Wilson:** Baycrest Centre is a prestigious, well-known, highly respected institution. Would it be fair to say that centres such as your own haven't been really told by the government what exactly this model is and how you'll be affected?

**Mr Greengarten:** To the best of my knowledge, we have not been told. We've certainly read the background documentation and the earlier reports. We have had an opportunity to discuss with ministry staff some of the possible implications, and we have had discussions with our colleagues and ministry staff to try to get more information about what some of the models might be.

1420

**Mr Jim Wilson:** Do you feel confident that you and your colleagues at the centre have a good idea of what this model will look like?

**Mr Greengarten:** No, I can't say that.

**The Chair:** Mr Sterling.

**Mr Sterling:** Thank you very much, Mr Chairman, for recognizing me.

I'm intrigued by your comment with regard to the definition of "vulnerable person" where it defines a vulnerable person as one who perceives that he is vulnerable. At least



that's the way I read that definition. I would like to ask counsel or the parliamentary assistant who they intend to include within that part of it. I'm concerned that the real people get served with regard to this legislation and not those who perceive that they should.

**The Chair:** Which parliamentary assistant?

**Mr Sterling:** The parliamentary assistant for the Minister of Citizenship.

**Mr Gary Malkowski (York East):** Right now, our legal counsel is on holiday. I would like to respond to that at a later date when our legal counsel has returned.

**Mr Sterling:** Okay, that's acceptable.

Could I ask another question of Mr Malkowski which relates more to policy? That is the request that groups like Friends or the Alzheimer society be represented on the commission, as obviously a person who is suffering from that disease is unable to represent himself. What is your reaction to that kind of request?

**Mr Malkowski:** In regard to the nominations committee, I believe that the organizations are able to nominate those whom they wish to represent them on the commission.

**Mr Sterling:** We're not talking about the advisory committee; we're talking about the commission.

**Mr Malkowski:** Yes, that's what I'm saying too.

**Mr Sterling:** That's the only question I had.

**Mr Morrow:** First of all, let me say I'd like to thank you for your strong endorsement of the amendments to Bill 109. I have a couple of quick questions. This will help me to define something. I'll read you a line here: "However, we believe that the position of rights adviser must be specifically defined." Can you go into a bit of detail on that, if you wouldn't mind, please?

**Mr Greengarten:** As you probably know, the term "rights adviser" has been substituted for the term "advocate" in Bill 109, but there's no definition. I believe the definition—I'm sorry I don't have it in front of me—refers to Bill 74, the Advocacy Act, but there's no definition in the Advocacy Act of "rights adviser" or what the responsibilities are.

We have some understanding, as the question earlier raised, of the position of rights adviser in psychiatric hospitals. We are comfortable with that role, but we're not clear whether that is the intent in Bill 109 or if there is some other intent in the use of the words "rights adviser." It seems to have been dropped in, perhaps without the background changes in Bill 74. That's really the purpose of the point.

**Mr Morrow:** Under your recommendation 4, where you talk about the monitoring of the impact of Bill 108 and Bill 109, who would actually do that monitoring?

**Mr Greengarten:** We have some interest in that because we have a competency clinic which is unique in Ontario and perhaps in Canada. We believe that we have some expertise there but we also believe that there are other capable individuals. Perhaps in concert with vulnerable persons and others, there might be some type of monitoring of the impact.

**The Chair:** Mr Malkowski?

**Mr Malkowski:** No, that's all right. I've taken care of it.

**Mr Owens:** In terms of your comments with respect to the limitation of access to the premises, how do you see that promoting a less adversarial relationship with the advocate? If a client in your residence has a concern about treatment or services that he or she is being provided, would it not be in the best interests of the client and the centre to allow advocates reasonably free access?

I'm concerned when you start tightening down on people's access to the institutions in which they are there to advocate on behalf of your clients. It's problematic in that you can only come in here within this prescribed period and you can only go in certain areas within the prescribed time and that in fact the institution may—and I'm not suggesting Baycrest would ever be involved in something like this—seek to obstruct, whether consciously or unconsciously, the role of the advocate.

**Mr Greengarten:** I think the way the legislation is, or at least we read the legislation—we may be misinterpreting it—it seems to be based on an assumption that vulnerable persons—and we're speaking of the elderly in our own submission; we aren't speaking of other groups—elderly persons in institutions require advocacy services that are different from elderly persons living in other premises or in the community. We question that apparent assumption, that apparent bias which appears to be built into the conditions. It's not that we're seeking to limit the access. We believe there should be access when there are reasonable grounds. We are talking about a situation where an individual has not asked for advocacy services.

As I read the context of this section, we're talking about a situation where there is no evidence that a person requires advocacy services, yet the advocate may have access to the facility, I suppose to try to find out if something is going on even though there's no objective evidence that there is something going on.

I guess just to finish, we treat our residents' premises in the institution as their homes, no different than their homes in the community, and so we have some concern about that.

**Mr Owens:** You use the words "case finding." My sense is that these individuals would probably be far too busy to need to seek out work. I'm sure the opposite in fact may be true, that they'll be looking to offload some of their case load. My understanding of groups like Concerned Friends is that there has to be a process that kicks in in order to have the group come into the premises, and in reading the legislation I'm not quite understanding why this particular section causes the kind of concern you've expressed.

1430

**Ms Carter:** I really want to follow up on the same point. We have amended the access provisions which are in section 18, and I'm just wondering what you would take exception to under that section. In other words, what opening is there for somebody to go on a fishing expedition, as



has been suggested? I don't see that from the wording of the act as it is now.

**Mr Greengarten:** We may be misreading it. If that's the case, we want to be sure we don't misinterpret it, but we didn't read the provisions in section 18, which I believe set out the responsibilities of the advocate, as necessarily applying for the right of entry when there is no evidence of the need for advocacy services.

**Ms Carter:** The specification given is "(a) a vulnerable person in the premises wants the services of an advocate," which I should have thought was fairly straightforward.

**Mr Greengarten:** I'm not sure if that refers to health care facilities or to private premises.

**Ms Carter:** This says "entitled to enter premises other than premises that the advocate is entitled to enter under section 17."

**Mr Greengarten:** It's a little complicated.

**Ms Carter:** Yes.

**Mr Greengarten:** As I said, if we misinterpreted, then we would withdraw the point. We haven't got legal advice on this or anything. We're just doing the best we can to interpret what we've read.

**Ms Carter:** Yes, and of course, if the vulnerable person has been reached by an advocate and then says he or she isn't interested, that person would leave immediately.

**Mr Greengarten:** That's correct, but our experience and our concern with respect to our clients is that 80% of our clients in residential services are cognitively impaired. If someone is asked, "Do you wish advocacy services?" it is not uncommon for the person to possibly say yes when he or she may not mean yes or may not understand the implications of the question.

I'm not saying we've had a legion of experiences, but we've had experiences of a well-meaning friend misinterpreting something that has been said and getting into arguments with family members and with staff and creating situations that, at the end of the day, don't benefit anyone but do perhaps create a lot of disturbance for the individual. This is what we're concerned about.

**Ms Carter:** I guess something like that might happen occasionally, but then you have to set that against the people who otherwise would not have been located who maybe do have a genuine problem.

**Mr Greengarten:** We would certainly support the view that older people who do not have family and friends to support them should have access to advocacy services.

**The Chair:** Thank you, Mrs Carter. Mr Greengarten, on behalf of the committee, I would like to thank you for taking the time out this afternoon and giving us your presentation.

**Mr Greengarten:** Thank you for the opportunity.

ONTARIO ASSOCIATION OF  
CHILDREN'S AID SOCIETIES

**The Chair:** I would like to call forward our next presenters from the Ontario Association of Children's Aid Societies. Good afternoon. Just as a reminder, you'll be

allowed half an hour for your presentation. We would appreciate it if you would keep your comments to about 15 minutes to allow time for questions and comments. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Ms Dianne Cresswell:** Good afternoon, ladies and gentlemen. I would like to introduce myself and my colleague. My name is Dianne Cresswell. I am with the Ontario Association of Children's Aid Societies. My colleague Sylvio Mainville is the managing director of the Hamilton-Wentworth Children's Aid Society. Mr Mainville can speak to the impact of the proposed legislation on the 400 children in the care of the Hamilton CAS and those children in the community who are served by the CAS.

You have before you our submission, and I will highlight parts of our submission.

Mr Chairman and committee members, we appreciate the invitation to appear before this committee to speak to the Consent to Treatment Act of 1992 and other related legislation.

We wish to advise the committee that the OACAS was aware of the Consent to Treatment Act early in its development. Although we had some concerns with reference to our responsibilities for children between 16 and 18, we understood the government's legitimate concerns about clarifying consent to treatment issues and felt we could live with the legislation, provided the age of consent remained at 16 and that the legislation was sensitive to the Child and Family Services Act and regulations.

We were further aware that the Ministry of Community and Social Services was working with those who were drafting legislation with regard to this concern.

On June 2, 1992, the Ministry of Community and Social Services invited us to a consultation on the legislation and we became aware of the recent amendments and in particular the removal of section 8 setting an age of 16 for capacity to consent.

It is the position of the Ontario Association of Children's Aid Societies that Bill 109 in its present form significantly undermines the principles and the intent of the Child and Family Services Act and is pervasive in its impact on the CFSA legislation.

Bill 109 fundamentally handicaps the children's aid societies of the province in their collective ability to fulfil their responsibilities under this government's own child protection legislation. The impact has been well documented by the previous submission of the Children's Aid Society of Metropolitan Toronto.

In developing this submission, the OACAS considered a recommendation that the Child and Family Services Act override Bill 109. We recognize the difficulties in this proposal and instead recommend the option of the consent to treatment legislation. Before proposing further amendments, I wish to speak to our concerns.

Although the primary focus of our submission will be responsibilities of children's aid societies under the CFSA, we feel the need to point out that the Consent to Treatment Act makes radical changes to provincial legislation and policy with reference to all families and in particular the



responsibilities of all parents in Ontario. The impact of this legislation, ladies and gentlemen, could potentially impact on your and my family and our abilities to make decisions on behalf of our children if in fact our children refuse or object to a treatment we deem necessary or appropriate for their health.

Seven years ago Ontario proclaimed the Child and Family Services Act, which was the result of a thorough and careful consideration of the need to balance the rights of children, their parents and the state. The CFSA also recognizes that a balance of rights among the parties is insufficient and articulates an overarching goal, promoting the best interests, protection and wellbeing of children. In our assessment, Bill 109 does not strike a similar balance, nor does it recognize the best interests principle.

We believe the new legislation is likely to increase the number of contentious cases with regard to consent to treatment issues. It is likely to promote family conflict even among well-functioning families which presently find a way to resolve their differences. The treatment process will be further complicated by placing health care providers between parents and children, allowing children under 16 to negate their parents' authority with regard to the decisions they feel are in their best interests.

Although the new responsibilities which are being proposed for children under 16 have some apparent benefit, namely, easier access to treatment and information services for health issues which children feel unable to discuss with their parents and the fact that children would have more control over decisions which affect their lives, there are serious drawbacks.

There is a likelihood of increasing family conflict by undermining the authority of the parents, increasing the anxiety and stress levels of children by placing responsibilities on their shoulders that they are sometimes unable to accept and increasing the responsibility of children for key decisions without accountability for their actions.

The CFSA is a fundamental and important piece of legislation that is notable because it integrates the numerous pieces of legislation which were previously not in harmony in terms of intent, principles or specific language and regulations.

We strongly request that the committee consider the 1990 report of the Advisory Committee on Children's Services entitled *Children First*. The recommendations include:

The entitlements of children must be incorporated in all existing and new legislation and also in policies that directly or indirectly affect the lives of the children.

All relevant legislation should be amended to reconfirm that the best interests of the child constitute the predominant test to which the child is entitled at every stage of contact with the courts or mandatory services.

All legislation affecting children and their families should be critically evaluated in order to establish legislative consistency with regard to age, access to judicial review, legal counsel, therapeutic assessment and entitlement to participate in reviews.

The new bill compromises the CFSA as opposed to working in harmony with it.

1440

We again refer you to the submission of the Children's Aid Society of Metropolitan Toronto and would like to remind you of the goal of the CFSA legislation, to promote the best interests, protection and wellbeing of children within the context of supporting the autonomy and integrity of the family, selecting the least disruptive course of action to help the children or family and providing service in a manner that respects children's needs for continuity of care and for stable family relationships while taking into account physical and mental developmental differences of children.

CASs have a statutory duty to investigate allegations that children are in need of protection, to prevent the circumstances leading to child maltreatment, to provide for the needs of children in care and the supervision of children at risk in the community. Courts presently have an ability to order that service be provided to an adolescent 16 years of age or over, even if the adolescent does not give consent. CASs have the ability to temporarily receive transfer of custody of a child from the parents in the form of a temporary care or special needs agreement, which authorizes the CAS to consent to medical treatment where the parents' consent would otherwise be required. A parent's refusal to provide necessary medical treatment for their child is grounds for a child to be considered in need of protection of the state.

CASs have responsibilities to ensure access to treatment and assessment services, including psychological and psychiatric evaluations, in addition to protecting the child. CASs are required to maintain a basic standard of medical care in the required plan of care for each of the children. Health practitioners provide ancillary consultant services and assist in the formulation of the required plans of care, but are not responsible for the plans themselves.

All these statutory duties either cannot be carried out or are significantly compromised by the proposed legislation. I think a few examples might assist, and I would ask Mr Mainville to make some comments.

**Mr Sylvio Mainville:** The first example concerns a 13-year-old girl, alleged to be sexually abused, who refused a medical examination. This refusal was not because of her incapacity but rather because of fear of consequences to herself and her family. Despite the violent nature of the relationship, abused children are often very dependent and loyal to their family. Refusing such an examination is crucial in the determination of whether the young person is infected with a sexually transmitted disease and to confirm the abuse.

Another case recently involved in a CAS had a dramatic example of a 14-year-old whose unborn child died in utero. The young person refused to have the baby aborted because of her fear of hospitals and medical procedures, despite her clear understanding that she was endangering her own life. In this situation, with the proposed legislation, children could make short-term avoidance decisions which have long-term, drastic and possibly fatal results.

The last example concerns a young girl, aged 15, who has a history of sexual and physical abuse as well as constant running away from home and is totally out of control



of her parents. She was at the point of being admitted into the care of the children's aid society, had a severe depression, for which medication was prescribed, and the young person refused the medication, as well as psychotherapy, against the advice of the plan of care and treatment prescribed by the society in consultation with other health professionals. Clearly this was not in the best interests of this young person.

**Ms Cresswell:** Children's aid societies in the province provide services to approximately 79,000 families with children in the community and care for approximately 20,000 children each year. Hundreds of these children have special needs and are developmentally handicapped, medically fragile or have behavioural problems. Over 15% of our children in care population are placed in resources that provide specialized services and treatment to children.

Children who are admitted to the care of a children's aid society have experienced the trauma of separation from parents and other siblings. Those who have been physically, sexually or emotionally abused are often withdrawn, highly anxious and intimidated by adults. Severe depression is often masked by acting out or contrary or oppositional behaviour.

It is not at all uncommon to find a child or adolescent initially objecting both to the admission to care itself and the separation from parents. Some children and youth object to participating in assessments, counselling services or treatment programs. Indeed it is the very authority of the parent or the substitute parent—the children's aid society—which enables the case plan to be implemented.

Allowing a child to refuse treatment can result in a child harming himself or herself, a child being exposed to further abuse or exploitation, a child perceiving the adult world around him as unprotective, an inability to improve family functioning such that a child can return home, a child resorting to criminal behaviour and a child suffering unnecessarily from a treatable illness that may lead to significant physical damage or subsequent death.

Children who have been in the care of children's aid societies and who have experienced such enormous emotional turmoil are often able to understand intellectually what is explained to them by adults and can exercise in a superficial way an ability to make decisions which may appear to be voluntary. These same children report years later how unable they were to absorb and retain information about what was happening to them and how little they understood about the implications of their situation and decisions that were being made at the time.

Children in care talk to their social workers very clearly about their need to know and understand, to know what is happening to them and to be involved in decisions about their lives. They also repeatedly talk about their need to be protected, for structure and for the adults around them to act responsibly on their behalf.

The Consent to Treatment Act proposes a mechanism for ensuring that children who cannot make capable decisions are able to access treatment that requires a capacity test to be applied by health practitioners. We have some concerns:

Many health care practitioners have neither the training or the knowledge of child development required to make such judgements. Many encounters with health care practitioners are very brief and not conducive to developing the knowledge of the individual child before them. The problem-solving process of relationships among children, families and service providers will be substituted by a legislative and bureaucratic process which cannot be sensitive enough to the complexities of the situation. There is a strong likelihood of increasing rather than decreasing parent-child conflict in families. Parents are not involved in the review board process. The definition of capacity is limited and is more akin, in our view, to competency. Competency does not consider the other factors that affect capacity, which includes a child's history and the nature of his or her present situation.

We recognize the genuine concerns of those drafting this legislation with regard to adolescents who may presently be denied access to treatment. Unfortunately, the proposed legislation inadvertently erects another barrier to treatment through a child's right of refusal in the context of a particular condition and/or life situation which compromises his decision-making capacity.

The Ontario Association of Children's Aid Societies recommends that the legislation be amended in the following way: that the age of 16 as the age of consent be reinstated with a rebuttal provision; that the mandate of the Consent and Capacity Review Board include provision for the review of a health practitioner's finding that a child is capable, and that the Consent and Capacity Review Board give party status to parents or guardians with lawful custody. This would include children's aid societies.

The OACAS recognizes the complexity of the consent to treatment issues and the genuine attempts to address the legitimate concerns about consistency and the access of children, especially adolescents, to certain types of treatment. We strongly object to the failure of this legislation to respect the principles and intent of the Child and Family Services Act and the legitimate and necessary role of parents in the first instance with respect to supporting the medical needs of their children.

The legislation is in conflict with the responsibilities of children's aid societies to protect children, and the children's aid societies' specific duties as custodial parents under the CFSA. In attempting to solve a legitimate problem, Bill 109 unwittingly creates a very real opportunity for seriously harming children, especially those who are already victimized and are extraordinarily vulnerable.

We thank you for the opportunity to speak with you today and we would welcome any questions.

1450

**Mrs Sullivan:** I wonder if we could clarify one area. First of all, the capacity of the children's aid societies to ensure that treatment occurs without the consent of the child is provided through regulation, or is it provided in the act?

**Ms Cresswell:** Would you repeat that? I'm sorry.



**Mrs Sullivan:** Is the power of the children's aid society to require treatment of a child included in the regulations to the CFSA or in the act itself?

**Ms Cresswell:** It is in the regulations.

**Mrs Sullivan:** It's in the regulations? Okay. I wanted to clarify that because it's caused some concern in our discussions.

**Ms Cresswell:** It is in the regulation for the child who is in the care of the children's aid society, but I would like to point out that in the appendix we have included the section "A Child in Need of Protection." If a child requires medical treatment—clause 37(e) of the act—and the parent refuses, then in fact the child could be deemed a child in need of protection, and then it would be the agency's responsibility to provide that treatment.

**Mrs Sullivan:** We have discussed earlier today many of the issues that you've raised in relationship to the age factor. I'm sure that will be a matter for continuing discussion, but I wanted to speak to the issue that you've raised about the standing of parents at the Consent and Capacity Review Board. I believe that it was certainly included in your brief, and in much of the correspondence I've been receiving from children's aid societies, that there's some concern about that.

The bill says that the capacity review board could include as a party to the application any other person whom the board specifies. Do you not think that if the children's aid society had custody of the child or if the parent were there, the board would insist the parent be named as a party to the application?

**Ms Cresswell:** We would hope that would be so, but the recommendations stand to ensure that.

**The Chair:** Mr Kwinter?

**Mr Kwinter:** No.

**The Chair:** Mr Sterling? Mr Wilson.

**Mr Jim Wilson:** No, I pass.

**Mr Morrow:** I have a bit of a lengthy question. When you apprehend a 15-year-old young woman who is a suspected victim of sexual abuse by her father, and you take her to the emergency department of a hospital for examination and she says she does not want to be touched by anyone, do you believe you have the authority to compel her to be examined against her will? Do doctors take authority from you and coerce her to be examined?

**Ms Cresswell:** In the situation of a 15-year-old, certainly the agency would attempt to persuade, to discuss with that child, that individual, the need for intervention, for assessment. We feel that this kind of legislation would provide some barriers to even that because the child would be allowed to have that right to refusal in a much quicker way.

One of the things we do in terms of intervening with any family is to begin to connect with that family to establish a relationship to assist the child and to assist the family. We feel that this bill, as it sits at this moment with the refusal section, could impair that.

**Mr Mainville:** It's a good question. Obviously, it makes a lot more sense to proceed with the consent of the

child. It's not as much of an issue, although it is an issue with the child welfare system. Keep in mind that our primary responsibility is the protection of the child. We've already removed the child from that situation if we feel strongly that the child has been sexually abused.

Where your question becomes more important is that if we're going to be able to proceed through the criminal justice system to prosecute the alleged abuser, then obviously you can get into a situation where you've got to have hard evidence. The test, of course, in the criminal system is different than in the child welfare system.

**Mr Morrow:** Given the first part of my question, under what authority would you be doing that, and can you give us the part of the act that actually allows you to do that?

**Mr Mainville:** Under section 37, if a child is in need of protection, the society has the authority to proceed with the apprehension of the child. Of course, that is subject to the society being accountable to the courts within five days. The society can remove the child, but within five days the society would have to appear before a judge in a court of law and give the reasons why the society acted to remove the child from that situation. Then the court, of course, would make the final decision.

**Mr Morrow:** That doesn't give you the power to force treatment, though, does it?

**Mr Mainville:** We have the power within the five days, subject to the court confirming that the child is in need of protection and can remain in the care and custody of the children's aid society. If we have care and custody, then effectively we become guardians of the child and we can consent to treatment on behalf of the child.

**Mr Morrow:** Thank you.

**Mr Wessinger:** I would just like to follow up on the statement on page 9 of your brief where you say, "Courts presently have the ability to order that service be provided to an adolescent 16 years of age"—you must mean "or younger"—"even if the adolescent does not give consent." I have some difficulty following what that is based on, in view of the fact that I understand the regulation which you referred to states expressly that the children's aid society has the same standing as a parent would have with respect to giving consent.

Following that up, it's very clear that a capable child's consent to treatment is required under the common law. On those bases, I have great difficulty understanding your statement on page 9. I wonder if you have any court authority for that or anything you can elaborate to us.

**Ms Cresswell:** The court can order an assessment of a child if the matter is brought before the court. I don't have the reference to the act with me, but I certainly could provide that to you.

**Mr Wessinger:** I'd agree with you that you can assess a child, but I would suggest to you that assessing a child is somewhat different than giving medical treatment or doing a medical examination against the wishes of a child. In fact, I would suggest to you that if a capable child refused treatment under the current situation and treatment were



administered or an examination were administered, there would be a situation of assault.

**Mr Owens:** Following up on the questions of my colleagues, in terms of playing the devil's advocate, if you have a kid who is coming out of a coercive situation in the home and more than likely is the victim of sexual and physical abuse, why is it problematic, that you wouldn't want to start the building of the rights at the point where that child comes into your care and start building a strong foundation, rather than putting him or her into another coercive environment, which is the CAS saying for better or for worse, "We think you need this treatment, we think this is good for you and we particularly don't feel that you have the capacity to decide for yourself"?

**Ms Cresswell:** In any situation in terms of treatment of a child, we would encourage the consent of the individual child. There is no question that we would encourage that and encourage the child to engage in that consent and engage in understanding that treatment. But in some of these situations, these children have so many other situational things that are impacting on their lives at that point that they are unable immediately to understand the need for that. If there is an opportunity to refuse immediately, it also gives us little opportunity to engage with the child and begin to build that relationship that is so important to help them move towards consenting and participating in treatment.

**Mr Owens:** Dr Peggy Robertson from the Toronto children's aid society testified at the last set of hearings prior to the adjournment of the House and I've met with her since that. We have some areas of agreement and there are areas we have some variance on. In terms of determining capacity in your role as care givers, what kinds of recommendations would you see? Do you see that as being an ongoing process rather than situational? Do you see where things may change from time to time? What type of advice would you give us on that?

**Ms Cresswell:** In terms of determining capacity in any situation, we would want to see children participate in the consent to treatment, to participate in the consent to assessment and then to treatment. That would be our prime goal in working with any child or any family. We would have to assess the situation on a case-by-case basis and then determine capacity based on an individual case basis. But in the main, we encourage consent to any intervention that the children's aid society proceeds in, if at all possible.

**Mr Sterling:** I am sure that from time to time government members get offended with opposition questions and that kind of thing. I've got to tell you that I'm offended with the government members' questions with regard to the role of the CAS, because I think you have one of the hardest jobs of any agency on behalf of the state in our province. In general, you perform your function admirably and I congratulate you for it.

The problem we have with this legislation is reflected by the questions which you have been asked by the government members today. It's adversarial. In other words, it's saying, "We mistrust the people who provide the services in this province," and that's why we have had great diffi-

culty, particularly with the Advocacy Act, because it is going to encourage people whom you are trying to help to avoid the treatment they need in a timely way.

**The Chair:** Ms Cresswell, Mr Mainville, on behalf of this committee, I would like to thank you for taking the time out this afternoon to give us your presentation.

**Ms Cresswell:** Thank you.

**The Chair:** Our next presenters aren't here so we'll recess for 20 minutes.

The committee recessed at 1503.

1530

#### JUSTICE FOR CHILDREN AND YOUTH

**The Chair:** I would like to call this committee back to order and call forward our next presenters, Justice for Children and Youth. Good afternoon. Just as a reminder, you will be allowed a half-hour for your presentation. The committee would appreciate it if you'd keep your comments to about 15 or 20 minutes to allow some time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Mr Brian Weagant:** My name is Brian Weagant and I'm the executive director of Justice for Children and Youth. I am accompanied by Sheena Scott and Cheryl Milne, both lawyers on staff. We appeared in front of this committee originally on this legislation and, in a nutshell, we support the amendments.

The way we think we can help you this afternoon is by responding to specific concerns you think we can help you with from our experience and, second, to respond to some of the positions that have been put to this committee, notably those of the Children's Aid Society of Metropolitan Toronto, the Hospital for Sick Children and Youthdale.

Perhaps I could begin by responding to certain things you heard today. I was sitting in and listening to the presentations of the groups this morning, and I think there are some things with which issue must be taken.

Both Youthdale and Sick Kids tried to paint the picture of legislation that's going to shut them down. There must be some blend of reality, practice and common sense in what's going to happen when this legislation comes in.

If I can begin first with Youthdale, the way they described the treatment being offered there, it has two components. It has a locked door, which means the young person is contained, and, second, they offer very intense personal therapy by way of group, by way of front-line engaging on a personal level with their kids, and the way they described it, a lot of it was verbal stuff. What no member of the committee asked these people was how any legislation in any way promotes or hinders that type of treatment going on.

They give the example of someone who is at home for three months, locked in his room; the only human contact he was getting was food through the door. Do you think if you have legislation that says, "We don't need your consent to talk to us," that's suddenly going to change that young person's condition and then he's suddenly going to



willingly engage in all kinds of group therapy that he wasn't before?

The legislation doesn't help or hinder. The consent of the child to participate is on a minute-by-minute basis and is probably controlled as much by how the treatment staff try to engage that young person in the available therapy as it does with anything else. There's nothing about telling the kid, "Your parents have consented to your being here; therefore, you have to talk to us," if it's going to change in any way that child's mental condition about whether he's going to want to talk to front-line staff or not.

The real message Youthdale was giving you, I think, was almost an in terrorem position. They're saying the second they meet any resistance, they're going to shut down. They're going to stop offering. They're going to bring this bureaucracy into play.

Isn't the reality with most of the types of kids they're talking about that you have to cajole them and you have to try to engage them in the treatment you want to offer? Isn't that what parents do with their kids? Isn't that the time-honoured way of getting kids to take needles when they're afraid of the pain? It's a cooperative effort within families and indeed within treatment programs. This legislation isn't going to affect that one iota.

The second thing Youthdale put to you which someone has to take issue with was the statement by its counsel that if you meet the admission for criteria, you automatically lack capacity. That must be questioned. A depressed teenager who's made some threats towards suicide can be very capable to make the decision about whether or not to talk to a therapist once put on the unit. The two things may have no connection at all. Indeed, the type of therapy they described to you that they're offering was something that would require a very low level of competence within which to cooperate.

If what they're really doing is trying to engage people on a personal level, you don't need a high degree of capacity in order to decide whether you're going to enter into a conversation with someone. The bold statement "If you've been admitted to our program, you lack capacity for any kind of decision-making" has to be questioned.

The Hospital for Sick Children: There were several things with which I think you have to take issue; first of all, the examples. Practically speaking, what happens now when a parent shows up at a hospital—the kid's being brought in by the parents—and the kid is resisting because he's afraid of the pain? I do believe this comes up on a moment-by-moment basis in hospitals. Hospitals don't tie kids down and treat them; that just doesn't go on. There must be some other mechanism for the treatment to be brought to that child.

I think it's quite clear that there is a cooperative effort between the service provider and the parent to allay the kid's fears, to engage him in what's going on, and in many cases parents prevail upon their children just by weight of the authority they exercise over them. Practitioners have been treating children who are afraid of doctors for years, dentists have been doing it for years, and they don't tie children into chairs. The law has nothing to do with how they treat them. The fact of the matter is, if kids are young,

there's a decision made within the family unit and the parents representing the children in some way prevail over the children to cooperate with treatment.

If the program shuts down, it's because the doctors are deciding "We won't treat the second we meet any kind of obstinance in children." It's an unacceptable position for the profession to be taking. They've never done it before, why would they do it now?

The example given this morning was of the girl failing at school who is brought into the hospital by her parents and she does not want to talk to the psychiatrist when she gets there. Does anyone really believe that if the hospital informs her that her parents have consented and therefore it's the law, she's now going to willingly engage in a relationship she might not have half an hour before? That's not the reality of how therapeutic relationships are formed. This legislation is irrelevant to what will happen once that girl is presented to the Hospital for Sick Kids.

The way the problem of the blood transfusion and the religious 13-year-old was framed for you was interesting. They said, "Right now what would happen is if we said the child needed the blood transfusion on an emergency basis and the parents refused on the child's behalf, then we would designate the child in need of protection and we'd have the children's aid over trying to apprehend the kid." Generally, there's a hearing within 24 hours in front of a judge to determine whether the child is in need of protection.

The way they put it to you was that this was a way of upholding the family's participation in these types of decisions. What's really happening there is the hospital has set the ball rolling down the hill to take all authority away from the parents. But they presented it to you that the way it's working now is of great benefit to parents because of the due process built into the mechanism that takes authority away from them.

Interestingly enough, there is case law in Toronto on that. There was a 13-year-old girl whose parents were refusing the treatment, and the court upheld the young woman's wishes not to be treated with a blood transfusion in that case. I believe the cite for that case is in the brief we've put in front of you.

I guess the message I'm trying to give you is that when they say the programs are going to necessarily be shut down because it's now codified that competent teenagers, who always had the right to refuse treatment, can refuse treatment, I think you should really question that. That's not what happens in reality now, and I don't know why anything should change once this legislation comes in.

One of my colleagues is going to respond to the CAS position.

1540

**Ms Cheryl Milne:** What I'd like to do is just explain what you have in front of you in terms of the paper we've provided. Brian sort of jumped into things right away. There are two documents we've given you. One is a supplementary brief to the brief we presented originally to the committee. We're not going to dwell upon that; there are just some general comments and then a reiteration of some



of our other recommendations which weren't followed in the amendments.

The other brief is a response to the Children's Aid Society of Metropolitan Toronto brief, which we've had an opportunity to review. We have some specific comments based on their interpretation of the law and how it affects kids in care. I'd just like to go through that briefly, and then Sheena Scott will also address one of the issues there. Then what we'd like to do—we'll try and do this as quickly as possible—is address some of your questions.

Essentially, it's our position that the common law is quite clear that children may consent to medical treatment if they have the capacity to understand the nature and consequences of the basic common law position. The position taken in the Children's Aid Society of Metropolitan Toronto brief seems to suggest that its interpretation was that the Child and Family Services Act modified that substantially, so that in a sense it was in a position to force children to undergo certain medical procedures to which it was consenting on their behalf.

One example given was a situation where a girl is brought in who discloses sexual abuse. Their position was that the reality of the physical examination to determine whether or not she had been sexually abused was non-negotiable; where it took place and whether she had friends with her at the time was something she had control over, but the issue of the examination itself was something the CAS would be consenting for. It's our position that this in fact is battery. If in fact that's what they're doing, they are forcing kids against their will, and that's just wrong in law.

Actually, we find it quite appalling that they would consider forcing an adolescent to undergo that kind of internal examination at a time when it may be very traumatic for her. In our view, in many instances that could be a further example of abuse.

In fact, a recent case we had in our office showed that those kinds of examinations with respect to evidence of abuse are somewhat limited, so it seems quite questionable as to whether or not this is something that is absolutely necessary in each case. There was a case where a girl had undergone an internal examination that proved penetration but, because she had started using tampons about three weeks before the examination, it had absolutely no benefit with respect to the criminal proceedings against the perpetrator. We really question the need for that kind of examination, specifically in a situation where the girl is refusing. In our view, the effect of that can be quite appalling if in fact she's being forced to undergo this kind of abuse.

There has been a trend, as Brian has stated, within the child welfare case law that suggests children are having a greater say. The courts are more willing to listen to the child's perspective in deciding the protection issue as it relates to medical treatment. That's the case called "In the Matter of Dianna S.," and it's on the second page of our response to the CAS brief—I'm sorry, it's "In the Matter of the Infant Lisa Dorothy K." The Dianna S case was the 1991 abortion case in which sort of the reverse happened; a child was found in need of protection in order that she could have an abortion, which was also what she wanted.

There is this trend towards listening to children in the protection proceedings. I would suggest that in neither of those cases was the full issue of capacity to consent to medical treatment dealt with. However, there is a history of case law that suggests minors have that capacity so long as they meet the criteria.

There are some specific recommendations that the CAS brief made, ones that we do not support. The first was that the CAS position was that a refusal of treatment by a capable child should be grounds for a protection hearing. That was in the context of parents having the responsibility for providing medical treatment to children and that they were held accountable through the protection proceeding if they did not provide that medical treatment or did not consent to it. The CAS position seemed to be saying that children were not held similarly accountable.

I would suggest that they were talking about apples and oranges there, that each individual is held accountable for his own decisions about his own body; and of course he's held accountable. If they have the capacity to understand the nature and consequences of the procedure, good or bad, then they are going to be taking the responsibility for their decisions, whether or not they go through with the treatment.

Second, the emergency provisions within the amended Bill 109 in our opinion are adequate to deal with many of the case examples given in the children's aid brief. Some of them were fairly alarming kinds of situations that we see not that infrequently in our office. It's our opinion that the emergency provisions can deal with those adequately, so I don't see that there's any need to provide for an override for capable children in emergency situations. I think they shouldn't be treated any differently.

**Ms Sheena Scott:** I just wanted to deal with one of the final children's aid recommendations. That was that parents and/or the children's aid be parties to a capacity review board hearing in all cases. It's our position that this would seriously undermine the issue of confidentiality.

When you or I go to the doctor, we don't necessarily want our parents or anyone else to know what we're going there for. If an issue as to our capacity comes up, we certainly don't want our family members necessarily sharing in the hearing as to whether we're capable or not. Should there be a final decision that we are incapable or an issue of substitute consent, only then at that time would disclosure be appropriate and the individual would still have the choice as to whether to disclose.

It's essentially our position that the legislation as it stands is sufficient in that it allows for the board to add other parties at its discretion and it could do so in an appropriate circumstance, but I think it would fly in the face of the basic principles of confidentiality and would discourage children and youth from seeking medical treatment, especially around sensitive issues such as birth control and abortion, if they could not seek a doctor's advice in confidence without potentially having their parents or the children's aid a party to their capacity review board hearing.

Now we'd like to answer any of your questions.



**Mr Kwinter:** I'd like to pick up on some of the things you just talked about. You refer to one matter on page 3 of your response to the Children's Aid Society of Metropolitan Toronto. It has to do with the whole idea that if a minor, someone who is aged 12, which is the bottom limit, is explained the repercussions or ramifications of a particular action he should have that right to make that decision as long as the person who is prescribing the treatment is satisfied that individual understands what is happening.

What you say at the top of page 3 is that they are held accountable through the consequences of refusing or consenting to treatment. What you had just said is, good or bad, at least they're accountable; they're going to suffer or they're going to benefit, but they have made the decision.

That gives me a lot of problems. A 12-year-old may understand in the context of a 12-year-old's experience and may give verbal agreement and talk about it, but he's still 12. They may make a decision that may be irreparable for the rest of their lives, but for you to say, "So what? They were told about it. They made the decision. Good or bad, they made the decision," totally negates parenting, totally negates the idea that experience is something that is valuable and that as long as you understand it and as long as you comprehend, it's your decision to make. I find that very difficult.

I find that difficult as a parent of four children who are all married and still come to me for advice. Most children find that the older they get, the smarter their parents get, because they suddenly realize that some of the decisions they have made have been in their best interests.

I understand there is a need to protect an individual's rights, but there's also an obligation, whether it's on the part of the CAS or parents, to exercise some kind of—I don't want to use the word "control" because there's a negative implication—some sort of advisory capacity to make decisions that person just doesn't have the capacity to make.

I know you're going to say, "Well, we're saying if they have the capacity," and I'm suggesting to you I don't know of a 12-year-old who has the capacity to make a life-altering decision in a 12-year-old experience of that particular child. There may be, in some instances, a situation where someone has to make that decision for them, even though they can verbalize what is being said and the doctor can say, "Do you understand what I'm saying to you?" They say, "Yes, I understand; this is the decision that I'm making." It may be the wrong decision and you're saying: "So what? They at least made the decision and they will bear the consequences of it." Do you have anything to say about that?

1550

**Ms Scott:** I just want to say something briefly about what you said about an advisory capacity. Certainly, we would agree with you that parents and, in the appropriate case, the CAS would have that capacity to advise. That's one thing the CAS didn't deal with in its brief. Very often they do engage, as Brian was saying, in trying to involve the youth in treatment and that's a very valuable thing. But there's a line to be drawn between that and making the

decision for the person if he or she is in fact capable. I think Brian had something he wanted to say.

**Mr Weagant:** There's an irony in the politics of age cutoffs. I don't know which party you're with, Mr Kwinter, but I'm sure it's one of the parties that supported criminalizing children under the age of 12. I believe Mr Scott was one of the people who pushed to have the Young Offenders Act age lowered. Mr Scott went to a conference of attorneys general from across Canada to make it easier to have teenagers treated as adults when they're involved in certain types of behaviour.

I have a hard time reconciling official positions around the age thing. We criminalize these people. We make them responsible in every other way for their actions. All we're saying is that they should have the ultimate decision, as well, over things affecting their bodies.

No one is saying this legislation says doctors can't involve the parents of younger children as they do now. Parents routinely go into doctors' offices with their children and the decision is made all at once. No one's saying the family should be cut out; we're just saying there's a final line and it should be the competent adolescent's decision.

**Mrs Sullivan:** On page 2 of your brief—and this is, I gather, your real brief, rather than the comments on other briefs that have been before us—you are speaking about the capacity review board and suggesting that a person ought to be able to have a right of appeal to the capacity review board if that person has requested a medical treatment from the doctor which the doctor has refused to provide.

**Ms Milne:** I am just wondering where you're referring to.

**Mrs Sullivan:** Page 2 of your brief, submissions on amendments to Bill 109 re rights advisers and counsel.

**Ms Milne:** Right. The wording of that particular section is with respect to something other than a psychiatric facility or prescribed health facility, so it was with the other group. We don't know, essentially, what you're talking about there. One of our general comments was that many of the provisions within the act relate to regulations that have yet to be set, so we really can't comment specifically on how those affect this group of our clients.

Our reading of it was that the triggering mechanism was an objection to the treatment or a request for a rights adviser. It didn't seem to cover, in the specific wording, a situation where a young person went to the health practitioner, requested a treatment and was turned down, unless they specifically asked for a rights adviser.

In our review of that section, it just seemed too narrow a situation. We were recommending that it be expanded to say that the rights adviser would be notified if the person objects to the health practitioner's finding of incapacity or disagrees with the treatment or refusal to treat. So if there's a situation in which a health practitioner is saying, "We will not provide the treatment that you're asking for because we believe you are not capable," then that in itself will be the triggering mechanism, rather than having them specifically request a rights adviser, because they may not know they have the right to request that.



In my reading of it, I think it is just that there seemed to be a slight oversight, but the difficulty we had was that it covered only situations other than the psychiatric facility or prescribed health facility. Treatment is a controlled act under the Regulated Health Professions Act, and there's a lot of vagueness as to what treatment was being referred to in that particular section.

**Mrs Sullivan:** That's not the way this reads. The way this reads is that the first reason the rights adviser should be called in is if the practitioner finds the person incapable, which is now included in the proposed amendments; and the second reason the rights adviser would be called in is if the patient himself or herself has requested that the health practitioner provide a certain medical treatment that the practitioner has refused to provide.

**Ms Milne:** I'm reading subsection 10(4). That is a specific reference to it. It says:

"A health practitioner who finds that a person who is 12 years of age or more is incapable with respect to a treatment shall ensure that a rights adviser is notified...if,

"(a) the finding is made in a psychiatric facility or prescribed health facility; or

"(b) the finding is made" within the other facilities or the other situations described "and the person objects to the treatment or requests a meeting with a rights adviser."

So it was either/or those two situations, and that's sub 10(4)(b).

**Mrs Sullivan:** And your recommendation, which is on page 2 of your brief—

**Ms Milne:** Is that this very small section be expanded to include—

**Mrs Sullivan:** Expanded quite substantially, and probably against the rules of the College of Physicians and Surgeons.

**Ms Milne:** The difficulty we have is that it's hard to comment specifically on where this fits in when we don't know what's contained in all the regulations that are supposed to go along with the act.

**Ms Scott:** Essentially, if someone refuses you a particular treatment, then you should have the mechanism to access that treatment in those circumstances as well.

**Mrs Sullivan:** Why?

**Ms Milne:** In the one sense, the health practitioner who has found the person incapable requested a certain treatment. I'll give an example—I'm not certain if that particular scenario would fit within this section—a situation where the young person requests an abortion. Just for argument's sake, if it fits within that section, then unless the person objects to the treatment—do you see what I'm saying? It's just not broad enough to cover a situation where they want the treatment. They're not objecting to the treatment; they want it, and the health practitioner says, "No, you're not capable to consent to it."

**Mrs Sullivan:** Certainly, that's not the way your recommendations read, and I find the planning problematic.

**Ms Milne:** We made a specific reference to 10(4)(b) with respect to that, and we weren't talking about it generally. As we said earlier, we generally support the amend-

ments. The recommendations in our supplementary brief are very specific because they're just more fine-tuning in that very specific section.

**Mr Sterling:** I would like to understand where you are coming from. Can you tell me who you represent?

**Ms Milne:** Our client group?

**Mr Sterling:** No. How are you funded?

**Ms Milne:** We are a legal aid clinic, a specialty clinic that represents low-income youth. Our clients are under 18. That's essentially it.

**The Chair:** Excuse me, Mr Sterling, could we recess for five minutes, being as we don't have any sound system? A five-minute recess.

The committee recessed at 1600.

1603

**The Chair:** I'd like to call this meeting back to order. I understand all our problems are fixed.

**Mr Sterling:** I was just asking Justice for Children and Youth, I find your position, that when skilled people around a child thought the child should be treated, the decision or the consent of an immature person was more important than the illness that might follow from not taking that treatment, an amazing position for you to put forward. Am I correct in assuming that is your position?

**Ms Scott:** If the child is capable, then we get into the issue of capacity.

**Mr Sterling:** That's your position?

**Ms Milne:** You have to make the assessment as to whether or not the person is capable. I suppose that immaturity plays a role in that kind of assessment, although we don't know what the specifics are of the capacity assessment. Our position is based on the assumption that we are talking about children who are capable. For the most part these are going to be adolescents over the age of 12, so they are going to fully comprehend the nature and the consequences of the decision they are making.

Most treatment decisions are decisions. What's going to happen is not a given. The people have a choice. Our position is that the young people who are capable, who understand the nature and the consequences, should have that choice.

**Mr Sterling:** But my question is about a person who is 12 or 13, who has suffered from sexual abuse, and there is a need perhaps to examine that young woman. She understands what's happened to her and she refuses. You are saying that the state or the parents should not step in and force that treatment, even if it's going to cause illness, after that?

**Ms Milne:** I believe the state and/or the parents—assuming that the parents are involved as a support in that situation, which is not always the case—have a role in terms of counselling that young person.

**Mr Sterling:** We all agree with that, but we know there's—

**Ms Milne:** I think that's the process. I don't think you force that girl to undergo a very intrusive procedure because you think that's a necessary part of the investigative



tool for a protection hearing, which is what we're hearing from children's aid societies that they want to have the power to do. I think if things are explained properly, that young person is going to make a decision in her best interests. It has been our experience with young people that they will. I don't think they should be treated any differently than an adult in the same situation.

**Mr Sterling:** You are saying that the right to decide for an immature person, in spite of the advice by the parents, the physicians and everybody else that this person is going to become ill, the right to make that decision by a 12- or 13-year-old woman is more important than the proper treatment of that young person? That's what you're telling me.

**Mr Weagant:** In a vacuum, yes; the answer is yes.

**Mr Sterling:** Okay, thank you.

**Mr Weagant:** But the specific example, surely—let me throw the ball back at you. How would you conduct an investigation on a victim of sexual abuse at that age who was saying, "I don't want you to do an internal examination"? Could you just describe for everyone what you would do in a situation like that if you didn't have the cooperation of that young girl?

**Mr Jim Wilson:** I think the position of the children's aid society was that they do not—unless you have some evidence or something you're trying to tell this committee in terms of accusations to the children's aid society, my understanding of their presentation to us this afternoon and their written brief was that they wanted the ability to give consent as the guardian of the child. I don't think there was any discussion of forcing. Those were your words. You had a setup question from Mr Morrow to the children's aid society. It was a follow-up, then, and you took from the children's aid society's response that they would somehow force the young woman to undergo this examination. I thought the question in the law was whether consent could be given for that examination.

**Mr Weagant:** If consent is a meaningless concept, what are we doing here? If you see it as consent and then the young girl can still say no, then really it's her consent that we're talking about.

**Ms Scott:** What's the logical consequence of their consent? Is it to put the girl on the table, open her legs up and stick the doctor's hand in? That's what you were implying should be done without her consent.

**Mr Weagant:** The bottom line is, is the girl going to control that situation or is it somebody else through their consent, if that's what consent really means? I thought that was what we were here talking about. There was, as far as I know, no setup question put by us or Mr Morrow. You've got your facts wrong.

**Mrs Sullivan:** No, there was a setup question. It may not have been put by you, but it was a setup.

**The Chair:** Thank you, Mr Wilson. Any further questions or comments?

**Mr Sterling:** As far as Youthdale treatment is concerned, I think you have portrayed its position wrongly here. As I took it from their brief that their position was

that the process that could be put forward by a young person under their care would forestall treatment for an unnecessarily lengthy period of time. They could use two acts, where they have one act to forestall that treatment, and therefore their efforts in terms of trying to help young people out would be fruitless or would be thwarted.

I did not take from their brief that they wanted to in any way get around the consent of the parents or the people and the individual involved, but that they wanted to get on with treatment within a reasonable period of time, and that they are a very busy agency because they are the agency of last resort; they have eight beds which are constantly sought. That was their position as far as I was concerned. It was that this was going to add to the existing processes, which was their greatest concern.

**Mr Weagant:** I was here for their presentation and you asked them specifically what kind of treatment it was they were talking about. They have a locked unit and they said that many times kids want the containment that offers and they offer this kind of engaging personal therapy. I go back to the original comment. How is that enhanced or thwarted in any way by any piece of legislation? Either the kids are going to engage or they're not. Everything is determined by the skill of the front-line worker.

1610

**Mr Sterling:** If this is, as they say, the residence of last resort, the children who are coming to them are very suspicious of everybody in society and therefore in order to gain the kind of confidence that is necessary, they need some kind of time in order to gain their confidence. Their objection with regard to Bill 109 is that the individual, because the individual is advised when he arrives at the scene that he can have advice, in taking that advice and being very suspicious of everybody, can forestall treatment as long as he possibly can. It is a very, very tenuous time with regard to the situation that arises. I think you've portrayed them as being against anything that brings into question the child's consent. That's the way I took it.

**Mr Weagant:** What you're talking about is dialogue with someone who's living there. It's something that happens on a minute-by-minute basis and it's a practical matter now. It's the bringing the horse to water problem. You can sit the kid in the psychiatrist's office and if he doesn't want to talk, he's not going to talk that day. I don't see where any of that's going to change. I understand what you're saying. I'm not portraying them in any particular way. I'm portraying the problem in a particular way. It's a more practical question than just, "The law says you've got to talk to me."

An interesting fact is that Sick Kids' doesn't have a locked unit any more; 6E is unlocked. It wasn't clear in 1988 whether they had to have all the protections under the Mental Health Act, but Sick Kids' decided to let the spirit of the act be in play. They arranged through legal aid that every kid who comes into 6E is given his rights, and if he wants to speak to a lawyer outside the hospital, our office is on call. Since 1988, three kids have asked us to come over and in none of those did they want to do anything legal



about their situation. They just wanted to confirm what their options were in life.

The floodgates argument, the ramifications of this, I don't know is necessarily going to happen. We're here to say that other people are telling you it's going to close the system down; we're saying that there's enough evidence out there to suggest that if it's done properly, nothing may change.

**Mr Sterling:** I just want to say one more thing. The big difference between them and you is that they are responsible for the treatment of the kids; you aren't.

**Ms Scott:** The legislation, we feel, is sufficient. There are provisions in terms of emergency treatment for various types of procedures, including intrusive procedures which could potentially come up at Youthdale. It would be our position that they are sufficient in order for the people at Youthdale to accept that responsibility adequately and properly and that the legislation will not impair them unduly.

**Mr Owens:** Contrary to my friends opposite, I found your presentations to be rather enlightening. I think that in this situation we tread a fairly fine line between the rights of the child and the rights of the state to intervene in situations. I would tend at this point to want to default to the rights of the child and I think the situations you have outlined in your brief quite reasonably demonstrate the need for the consent-to-treatment legislation.

In terms of your comments with respect to clause 10(4)(b), I think you hit the nail right on the head. It's not only a situation where treatment is being refused, but in some smaller communities, some small-c conservative physicians may in fact refuse to provide an abortion to a young woman for whatever reason he or she may deem as being reasonable. That kind of situation needs to be dealt with in legislation.

One of my concerns with centres like Youthdale—I'm not pointing the finger at them particularly because they are an acute care setting and, unless I'm corrected, it's my view that the emergency procedures under this legislation would enable them to provide whatever treatment is required. I would agree with you folks that my interpretation is that it tends to be verbal and collegial as opposed to coercive and tie the kid down. I don't think that kind of treatment works in any kind of setting. Having had to visit the Hospital for Sick Children on a number of occasions as a young person and being faced with a needle or any kind of treatment wasn't always a pleasant alternative, but there are ways and negotiations and it may take a little bit more time. Again, if the situation is so serious that an intervention has to be made immediately then the emergency provisions would tend to kick in.

I certainly empathize with your brief and I know your group does excellent work. I have had the pleasure of working with some counsel from your organization and I encourage you to keep coming back to this committee and to this government advocating for the rights of children and adolescents in the manner that you've done; it's the kind of input.

Mr Sterling had a point that you don't care for the children. In fact, you do. As a counsellor, you certainly

have a duty to those children, and there is a penalty for not representing those children effectively. There are penalties and there are sanctions.

**Mr Sterling:** They don't pay any penalty; that's the problem.

**The Chair:** Order, please.

**Mr Owens:** Mr Sterling made a point earlier about comments and being offended at comments. I can certainly tell Mr Sterling that I was clearly offended not only by his line of questioning—

**Mr Sterling:** Good. I can understand that.

**Mr Owens:** —but the cheap shot he took at this organization.

Again, I thank you for your excellent presentation and urge you to continue to do the excellent work you do for kids in this province.

**The Chair:** As was stated at the beginning of this whole process, the Chair is going to exercise a little bit of flexibility. We are over time, but I'll allow Mr Kwinter one brief comment.

**Mr Kwinter:** I just want to throw out another example, because I've listened to the Youthdale scenario, which is at the extreme end. I've listened to the story about the young girl who really doesn't want to have an internal examination performed on her, but let's talk about a situation Dr Goldbloom talked about this morning from Sick Children's Hospital.

A youngster comes into the emergency ward and he's got a shattered leg. The doctor sits down and says to him: "We're going to have to operate. We're going to have to open up your leg. We're going to have to drill three holes and put in three stainless steel pins, and that's going to fix your leg; if you don't you're going to limp." The kid says, "Well, how badly am I going to limp?" He says, "Well, you're going to have a little bit of a limp." He decides that the idea of having someone drill into his leg and put in screws and cut him open is far worse; he can tolerate a little limp. He says: "You know what? I don't want the operation. I'll limp."

Because it isn't life-threatening, the doctor can't do anything about it. Do you think it's responsible to say: "I understand it. You've told me what it is. I'm convinced that I can tolerate the limp for the rest of my life"? This is someone at 12. What do you do?

**Mr Weagant:** If the 12-year-old kid is there with his parent and the kid says, "No way anybody is touching me," what happens now?

**Ms Scott:** Don't you think the doctor would be concerned about a battery suit if he would have touched that kid when the kid was refusing now?

**Mr Weagant:** Isn't there, as my friend said, a collegial decision made and parental authority prevails?

**Mr Kwinter:** You're saying that parental authority has nothing to do with it.

**Mr Weagant:** I'm saying that parental authority is going to influence that kid ultimately cooperating. I was 12 once; I remember how cooperative I was with any of that kind of stuff. At the end of the day, I generally agreed with

whatever was being offered once I was convinced it was in my best interests. Right now, if that kid is confident the doctor shouldn't be treating him, but for some reason that kid is being treated today, I'm just wondering how it's happening now.

**Ms Scott:** Also, the legislation speaks of serious bodily harm or a risk of serious bodily harm, and that also leaves some flexibility.

**The Chair:** Mr Weagant, Ms Milne and Ms Scott, on behalf of this committee, I'd like to thank you for taking the time out this afternoon and giving us your presentation.

Just a reminder, there'll be a subcommittee meeting at 10:30 tomorrow morning. This committee stands adjourned until 10 o'clock tomorrow morning.

The committee adjourned at 1621.



## CONTENTS

Wednesday 5 August 1992

<b>Advocacy Act, 1992, and companion legislation</b> . . . . .	J-71
Ontario Association of Professional Social Workers . . . . .	J-71
Susan Roher, chairperson, task force on advocacy legislation	
Doris Baker, member	
Carol Eisenberg, member	
Hospital for Sick Children, Medical Advisory Committee . . . . .	J-75
Dr Alan Goldbloom, committee representative	
Dr Françoise Baylis, bioethicist	
Youthdale Treatment Centres Ltd . . . . .	J-79
Hugh Kelly, solicitor	
Dr Jim Deutsch, director, crisis unit	
Paul Allen, assistant director, administration	
Baycrest Centre for Geriatric Care . . . . .	J-84
Moshe Greengarten, vice-president, public affairs	
Ontario Association of Children's Aid Societies . . . . .	J-88
Dianne Cresswell, manager, communications	
Sylvio Mainville, managing director, Hamilton-Wentworth Children's Aid Society	
Justice for Children and Youth . . . . .	J-92
Cheryl Milne, staff legal counsel	
Sheena Scott, staff legal counsel	
Brian Weagant, executive director	

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

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- \*Kwinter, Monte (Wilson Heights L) for Mr Mahoney
- \*Owens, Stephen (Scarborough Centre ND) for Mr Winner
- \*Sterling, Norman W. (Carleton PC) for Mr Harnick
- \*Sullivan, Barbara (Halton Centre L) for Mr Chiarelli
- \*Wilson, Jim (Simcoe West/-Ouest PC) for Mr Runciman

\*In attendance / présents

### Also taking part / Autres participants et participantes:

Fram, Steve, counsel, policy development division, Ministry of the Attorney General  
Malkowski, Gary, parliamentary assistant to the Minister of Citizenship

Clerk / Greffière: Freedman, Lisa

Staff / Personnel: Swift, Susan, research officer, Legislative Research Service



## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Thursday 6 August 1992

### Standing committee on administration of justice

Advocacy Act, 1992,  
and companion legislation

Subcommittee report

Chair: Mike Cooper  
Clerk: Lisa Freedman



## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Jeudi 6 août 1992

### Comité permanent de l'administration de la justice

Loi de 1992 sur l'intervention  
et les projets de loi  
qui l'accompagnent

Rapport de sous-comité

Président : Mike Cooper  
Greffière : Lisa Freedman



### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

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### **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Thursday 6 August 1992

The committee met at 1010 in committee room 1.

### ADVOCACY ACT, 1992, AND COMPANION LEGISLATION LOI DE 1992 SUR L'INTERVENTION ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervenants en faveur des personnes vulnérables; Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne; Bill 109, An Act respecting Consent to Treatment / Loi concernant le consentement au traitement; and Bill 110, An Act to amend certain Statutes of Ontario consequent upon the enactment of the Consent to Treatment Act, 1992 and the Substitute Decisions Act, 1992 / Loi modifiant certaines lois de l'Ontario par suite de l'adoption de la Loi de 1992 sur le consentement au traitement et de la Loi de 1992 sur la prise de décisions au nom d'autrui.

**The Chair (Mr Mike Cooper):** I'd like to call this meeting of the standing committee on administration of justice to order. This is the second round of hearings on the amendments to the advocacy package.

Before we start, we have the answer to Mr Sterling's question of yesterday, if you would, please.

**Ms Mary Beth Valentine:** Mr Sterling, I'd like to make the point that I'm not giving a legal counsel perspective. I'm not legal counsel and I wouldn't want to get myself into hot water.

The issue relates basically to the concept of disability policy. There is a World Health Organization document called International Classification of Impairments, Disabilities and Handicaps that basically sets out—

**Mr Sterling:** For other people in the committee, I think the question relates to what "perceived" is in the definition.

**Ms Valentine:** I'm sorry. Yes. Why the act was amended to include the words "or perceived" in the term, "disability, whether actual or perceived," and that was clearly the change. The question Mr Sterling raised was why "perceived" had been included.

**Mr Sterling:** In the definition of who is a vulnerable person. In other words, it's somebody who has a disability. It doesn't matter whether that disability is actual or perceived. The "or perceived" was added in the amendments. My question was why it puts in that "or perceived."

**Ms Valentine:** The World Health Organization document International Classification of Impairments, Disabilities

and Handicaps recommends that disability policy world-wide be established considering the three distinct concepts of disability.

The first concept is impairment, which is considered the basic ideology, the disease, the disorder etc that creates a disability. The disability itself is the second concept. It's the actual limitation of activities, a functional disability, the functional limitations. The third concept is the handicap. The term "handicap" has to be considered in the context of the environmental factors: the society the person is in and the societal role of individuals, attitudes, roles and perceptions, the impact on our perceptions as a society and the impact that has on disabled people.

In particular, the Canadian Classification of Disability, Impairment and Handicapped, which is sort of a secondary document to the WHO document, stresses the fact that the handicapping concept is a situational result of the person's interactions with the environment, not simply a result of the impairment and the disability.

From this perspective, persons may face handicapping situations that are completely based on societal factors such as misunderstanding, fear, ignorance, stereotypes and stigma, thus a perceived disability. People's limitations are often not based on their own ability or disability but on the labels we as a society have placed on them.

People First of Ontario will be presenting this afternoon, I believe. For them the issue of labelling, for instance, is very important. I hate to use some of the types of derogatory terms, but you could think of the issue of labels in the same sense as racism and the types of terms that used to be used to refer to certain classes of people, and I suppose certain races of people etc that I suppose still are in some situations.

By the same token, terms like "retard," "dumb" and "gimp" are the types of terms that people with a disability have been extremely conscious of over the years, of those types of attitudes actually having an effect on people's perception of them and their abilities.

Obviously this is an extremely sort of sensitive issue for people with disabilities and disability groups. It relates to the Obstacles report that you will probably remember, Mr Sterling, in particular because you were a member during the era of the disability issue, the Ontario Year of the Disabled Person. Then the ongoing Decade of Disabled Persons and the Obstacles report that came out reinforced the same concepts.

Quite frankly, the amendment is also directly a response to the disability groups represented by the Ontario Advocacy Coalition. The advocacy coalition in its presentation specifically asked for this amendment to be made. I honestly didn't have the time last night to go back and look and check and see what other groups had also requested the amendment, but there are certainly a number



of individual groups that have approached the minister or the Office for Disability Issues wanting to make sure the inclusion was in the act.

**Mr Sterling:** Can I just ask a supplementary, with your indulgence?

**Ms Eva Nichols:** This is of great interest to us anyway, so it's fine.

**Mr Sterling:** I guess my concern about including "or perceived" is that I had hoped that if in fact the Advocacy Commission was set up and went ahead, it would be dealing with real problems for vulnerable people; in other words, that we would be dealing with real issues.

Would this definition not leave it open for people who wanted assistance in lobbying, assistance in promoting their own self-interest in some way, be it an individual or a group? Would it not put the Advocacy Commission in the vulnerable position itself of having to respond to people who really were not vulnerable people and were not what the intent of the commission was set up for?

**Ms Valentine:** I think it has to be very closely tied in with the other parts of the definition, and clearly the definition says that a person has to have a moderate to severe disability and that he has to have difficulty in expressing his own wishes, acting on his own behalf. So there have to be the first two situational criteria there before they would be eligible to start with.

The third issue would come into play, probably not in an actual open discussion, around a labelling type of situation or around a situation where a person perhaps had a difference in opinion with a physician or an employer or whatever about what the label was that he had. Psychiatric clients would often question their diagnosis, and again with good reason, in that on repeated admissions their diagnosis frequently changes. They might be labelled schizophrenic one time, schizo-affective another time, affective disorder. You don't have to agree with the label to agree that you have a problem, so perceptions are important in that concept to some people.

I don't think it changes in any way the intent of the act and I can't honestly tell you why it wasn't included in the first place. I think probably if the draftspersons at the time had been familiar with disability policy, it would have been included.

**Mr Sterling:** I don't agree with its inclusion. I think you're leaving the Advocacy Commission open to utilization by people who should be using other avenues to promote their causes. I really think the Advocacy Commission is going to have a difficult time turning away anybody under this definition. Anybody in society is going to fit into the vulnerable category as a result of putting in the "perceived" part in the definition. I think that is unfortunate, but I understand your arguments. I think your arguments make sense, but not within the definition.

1020

#### LEARNING DISABILITIES ASSOCIATION OF ONTARIO

**The Chair:** I'd like to call forward our first presenters today, from the Learning Disabilities Association of Ontario.

Good morning. Just as a reminder, you will be allowed a half-hour for your presentation. The committee would appreciate it if you would keep your remarks to about 15 or 20 minutes to allow time for questions and comments from each of the caucuses. I understand that you don't have a prepared brief, so please, as soon as you are comfortable, identify yourselves for the record and then proceed.

**Ms Nichols:** Thank you very much. My name is Eva Nichols and I'm the executive director of the Learning Disabilities Association of Ontario. With me is Tanya Lewis, who is a resource counsellor working in the provincial office for the association.

We appreciate this second opportunity to come back before you and present some further comments about the amended version of Bill 74. Our remarks will focus exclusively on that particular bill and not the other accompanying bills.

The Learning Disabilities Association of Ontario is an advocacy organization that has been in existence for some 29 years. We advocate on behalf of those people who are identified or who are presumed to have a learning disability. Perhaps the "perceived" problem comes into that situation, because the majority of people who have learning disabilities in fact are not identified, very largely because when they went to school such identification still wasn't around. We represent about 10% of the general population, approximately 800,000 people in the province of Ontario who have learning disabilities.

First, I'd like to comment that many of the amendments that you recommended and that have been included in this revised version reflect some of the concerns that we had before. On that, I'd like to compliment you and thank you on behalf of our population.

Second, there are eight very specific points that I would like to make in relation to what we now have in front of us in terms of Bill 74. I'd just like to run through those. It will not take very long, and then hopefully there will be an opportunity for questions and dialogue.

Starting out with the first comment, in section 2 under "Definitions" the current recommended definitions of "advocate" and "community agency" both talk about these individuals acting on behalf of the commission. I'd like to put in front of you a concern that where advocates and community agencies act on behalf of an external organization which is appointed and reports to government, in many respects this creates a problem for consumers and for those community agencies.

Very often the kind of advocacy, especially the systemic advocacy, that organizations like ours get involved in relates to legislation which is discriminatory in nature. In a different forum, we were delighted to see that Mary Cornish recommended in the human rights reform that there should be group action allowed on human rights cases. We are just concerned that if in fact all advocacy and all community agency advocacy occurs on behalf of the commission, people will feel that they have one hand tied behind their back and cannot act in a totally independent fashion on behalf of the consumer.

Second, in the definition of "vulnerable person" I would like to bring in front of you the concern we had last



time, which is that when it is limited to "mental or physical disability, illness or infirmity," it leaves some rather major gaps which currently exist in various parts of Ontario legislation, and people with certain kinds of disabilities that, strictly speaking, do not fit either under the mental or the physical disability label in Ontario are currently left out of certain programs and services.

It seems to us that it would be much more appropriate if the definition either made reference to the human rights code definition of "handicap" and used the same categories, so that there is that correlation, or, alternatively, made reference to the various categories that are delineated in section 15 in terms of the organizations, so that there are no groups of vulnerable people that, in some people's eyes, do not fall under the category of mental or physical handicap and therefore can be excluded.

Currently, this is a very major problem for people with learning disabilities that are excluded from all kinds of government services and funding opportunities on the ground that in the eyes of the Ontario legislators learning disabilities are not a mental or physical disability. We feel very strongly that it could leave a gap that would really provide disservice to our population.

In subsections 7(2) and 7(3), once again there is reference to the role of non-profit community agencies in providing advocacy services. Again I would just like to comment that it seems to us that these services should not be provided on behalf of the commission, but rather on behalf of the consumers whom these agencies represent.

I would like to refer you to this report on human rights reform that Mary Cornish tabled. In recommendation 6, there is some really interesting discussion about the role of community agencies in providing advocacy services for those people who need those. It would seem to me that it would be a very good idea if there was some correlation between these various initiatives.

In section 8 of the amended act, there is some discussion about the structure of the commission and how advocates are to be paid and so on. We have a concern that the Advocacy Commission should not become a really major bureaucracy. We are looking at the Ontario Training and Adjustment Board structure that is currently being set up, which seems to be getting bigger and bigger and bigger, and all that is happening is that money is being allocated to structures and systems and commissions and boards. We feel that, yes, training is very important, but advocacy is of vital importance to the kind of people we represent. We just want to be very sure that the primary allocation of funds will not be to the bureaucracy but to real services to real people who have real needs.

In paragraph 15(1)2, "learning disability" is included as a "physical disability, illness or infirmity that is not readily apparent." When the first reading of Bill 74 occurred, we immediately called the minister's office, pointing out that learning disabilities are not and have never been identified by anybody as a physical disability. We expressed the concern that by including it there, it again will become about as invisible as it is in the people who have it.

We were told at that time that, yes, they recognized that indeed there was a minor error in that, but there had been

some rush about preparing this bill and that it could be amended later. That amendment has not occurred, and we feel very strongly that either learning disabilities should be in a separate category in those organizations and those definitions—because, after all, it is a very large group of people who are vulnerable—or, if you don't wish to add an additional category, it should be included in subsection (6) with neurological impairment such as autism and Alzheimer's.

If one looks at such things as the World Health Organization definitions and the DSM-3—from the Diagnostic and Statistical Manual of Mental Disorders—and various other categories of disabilities and so on, learning disabilities are always included with neurological impairments and are viewed as being on the same continuum as such things as autism. We feel very strongly that it's important that this kind of categorization be accurately done and that it reflect the facts.

We would like to recommend that somewhere in this act there be some clarification of the situation for vulnerable individuals who are aged between 16 and 18 and who may still be in school. Our association wrote to the minister after Bill 74 was tabled to express our concern about 16-year-olds who are still in school and who, because of what happened with the freedom of information act and because of what is presumed to come from the Advocacy Act, are now having to assume responsibility for certain things relating to special education. The school boards in many cases are excluding the parents from participating in any of the discussions and so on.

#### 1030

The minister wrote back to us at some length about the role of parents and said:

"In most societies parents, by definition, are guardians of and advocates for their children. Children do not have independent legal status from their parents or otherwise appointed guardians until they reach the age of 18, although children between the ages 16 to 18 have more legal autonomy than those under 16, and Bill 74, the Advocacy Act, will not change the legal status of children or the role of parents."

We feel that the current act does not adequately address the situation for those 16- to 18-year-olds who are still in school and who are involved in various educational decisions.

We would like to recommend that either follow-up regulations or the act itself should deal with the issue of disclosure of information as laid out in sections 29 to 33. It is a very complex set of directions that are laid out there about where advocates may and where advocates shall disclose.

If indeed we want this whole advocacy process to be responsive to the needs of vulnerable people and if we want even small community agencies to be able to work with it, I think it's very important that be explained very well and that, whatever training is offered to advocates by anybody, all of that is really focused upon. I think for some individuals the differences between "may" and "shall" and the threat of possible fines is going to be a very scary prospect and I think you need to be sensitive to that.



In clause 36(1)(c) there is some discussion about procedures and standards governing the provision of advocacy services by community agencies and their advocates. It is very important that community agencies recognize that what are laid down in legislation and in regulations are guidelines, but that they are not absolutely bound by a pre-set set of procedures and standards. The whole strength of the kind of non-profit voluntary agency system we have in this province is that in many cases they have autonomy in how they practice within the strictures of the law.

I think that for some organizations the hint of very tight controls is going to be a really threatening one and perhaps that section could be softened or elaborated upon in such a way that small community agencies are not going to feel they are totally bound.

Finally, we would like to raise again the question that there are advocacy components included in the proposed Employment Equity Act within the Human Rights Code and certainly the human rights reform that has been put forward. We feel it is very, very important again for consumers, vulnerable individuals and community organizations that, if there is going to be a whole series of systems for the delivery of advocacy services, they are the same so that you don't have one set of advocacy procedures when you deal with employment equity and another one when you deal with human rights and another one when you deal with pay equity and so on.

I think that because we want this to be a responsive system which responds to the needs of consumers and their organizations, there should not have to be a whole series of different procedures for community agencies and for advocates to learn and to try to remember that right now we use this kind but tomorrow we might have to use a completely different kind of advocacy system.

Thank you. Those are our comments on Bill 74.

**The Chair:** Thank you very much. Questions and comments?

**Mr Monte Kwinter (Wilson Heights):** I'd just like to ask you a question about one of your suggestions on section 15. What is the practical effect of moving learning disabilities from category 2 to category 6? Does it do anything for you other than you feel that would be a better place to have it listed in the act?

**Ms Nichols:** There was reference made earlier about how organizations and consumers feel about labels and certainly that's a very hot and thorny issue within the disability community.

Because people with learning disabilities are denied so many services and so many opportunities currently, it really is very important to our organization and to the consumers we represent that learning disabilities are correctly designated and they are recognized for what they really are.

I think all it does is it corrects an error. We know it is not a physical disability, and in terms of what the organization gets out of it, no, there is nothing very much, but what the individuals who have the disability get out of it is a much more appropriate identification.

Ideally, yes, we would like to see it in a separate category because we are representing a very large number of

people and we would like to be assured of the opportunity of being involved with the commission, but if that is not possible, then at least I think it is important for our consumers that it is correctly identified. They seem to spend an awful lot of time battling existing organization systems, mainly within government, about whether a learning disability is a real disability. I don't think that is an issue here because clearly it is recognized. I think it is very important for them, though, that it is correctly identified as a neurological problem and not a physical problem.

**Mrs Barbara Sullivan (Halton Centre):** I thought your presentation today was very interesting. I want to pursue some of the discussion you raised about the potential of the expanding bureaucracy associated with the Advocacy Commission and its effect on the volunteer organizations.

You indicated in your remarks that in your view the volunteer organizations should be able to see the legislation and the regulations of the commission more as guidelines so that they could function in the way that most appropriately met the needs of their communities. In fact, that's not what the bill will provide. The bill will provide for quite determined and explicit rules with respect to reporting and the conditions around which the advocates must work, which are included in the bill, plus regulations that none of us has seen and none of us knows about, which are of some concern to us because in fact we don't know what the parameters of those regulations are.

I'd like you to expand for the record on how you see the commission's involvement in determining standards for advocacy organizations affecting a group such as the Learning Disabilities Association of Ontario.

**Ms Nichols:** I would imagine that the Advocacy Commission—and I agree with you, we don't have any regulations—would function in somewhat the same kind of way as the Ontario Human Rights Commission, in other words, dealing with issues that are brought to it and advising agencies how to proceed. An organization such as ours currently certainly spends a lot of time reviewing legislation and reviewing regulations and setting up ways that we can deliver advocacy services within that legislation.

Just because of where our organization is most effective, a great deal of that relates to the Education Act. Of course there isn't a commission of that nature, but certainly under the Education Act and the accompanying regulations, we have set up a process whereby people who represent our association work with school boards, and we certainly control how they carry out those advocacy tasks. We would have no problem with being accountable as a provincial organization to a government-level commission as to how that kind of a process functions.

Where I see the concern is in the advocacy we carry out at the provincial level, which is primarily systemic advocacy, and, second, our 52 local groups who do much more individual advocacy—all of that has to be on behalf of the commission. I can see us having a tremendous amount of administrative and supervisory activity going on which really would not be in the best interests of our consumers. Quite honestly, if our staff in our provincial



office, for example, spent its time supervising advocates throughout the province with the 52 local groups we have, then clearly those people would not be delivering the kind of services that people want of us.

1040

I know money is not the most important thing, but it's pretty important, and if in fact we will continue to function as we do, funded entirely through charitable donations, I'm not at all sure the corporations and foundations and individuals who currently give us their money to spend on behalf of individuals with learning disabilities would be quite as responsive if we said, "We spend a large amount of money reporting to a government commission, and we spend a large amount of money supervising people in the field in terms of their advocacy."

Obviously, there is a reporting structure in place now, and we do try and keep very much on top of what individuals who represent our association do, but at least we don't have this sort of additional structure.

The other issue that is suggested in this is that the pay of advocates should be as delineated by the commission, including benefit packages and so on. I'm sure that all of you who are involved with non-profit organizations know that the only reason we can have the kind of non-profit organizations we do is because there are lots of people in this province who are prepared to work for very little money, no benefits and long hours because they really are committed to it.

If we are going to have a situation where some of the people who work for the non-profit agencies will be commission advocates and they will have to be paid one way and have one set of benefits, we are going to have some fairly major internal problems with the other people who deliver the other services we offer who will not have those kinds of things.

Those are the reasons why we are concerned about everything being on behalf of, rather than under guidelines set by the commission.

**Mrs Sullivan:** I don't want to steal from my colleagues' time, but I do want to ask one other question. If there are a limited number of resources, which clearly there are in terms of volunteer organizations or other organizations, as the executive director, presumably subject to a board, what would your recommendation be in terms of delivery and use of those resources? Would it be to provide primacy to your requirement and your obligations under the Education Act or under the requirements of the commission?

**Ms Nichols:** That's a very difficult question to answer. If you were to ask me what I see as the most important thing for us as an organization, advocacy or education, then there is no question. Advocacy is the most important thing for us to do, because it's a cliché that children grow into adults. Frankly, whereas the children of this province are served not too badly one way or another, there are many adults who really are falling through the cracks, and it really requires some significant advocacy. But if it comes to the fact of people working locally with school boards versus the provincial level, working with a structure, a commission, then I would have to say that our board of

directors would probably opt for the local, very much more hands-on sort of thing.

The limited resources for advocacy should really go into such things as training people to be advocates, and as much as possible supporting vulnerable individuals to access the services of advocates so that they can get services and funding for things they need; in other words, very much more the decentralized, grass-roots type of thing rather than a great deal of administrative structure at Queen's Park.

**Mr Jim Wilson (Simcoe West):** Thank you for your presentation. This is really more of a comment or observation. A great deal of time has lapsed since the first round of public hearings and it strikes me today that many of your comments are similar to, and many of your problems or concerns that you raise are still unresolved from what we heard in the first round of public hearings.

Are you getting any satisfaction or degree of comfort that you're being listened to? You've seen 199 amendments come in. Do you have any general comments on that or any salient pieces of advice you'd like to leave with the committee?

**Ms Nichols:** To be involved with the Learning Disabilities Association of Ontario in the province of Ontario in 1992 is a very frustrating experience, but it doesn't just relate to the Advocacy Commission. It relates, for example, to the fact that we have had an interministerial working group looking at the status of people with learning disabilities in Ontario that has created a really powerful report which has not been released and which none of you has seen as yet. It's being held up because of administrative problems.

Although certainly, when we talk to individuals such as yourselves or to individual civil servants, we always get a very responsive hearing and people always tell us that they understand why we are frustrated, why we are concerned in terms of systemic change, at the moment it really does not appear to be happening.

I think where we have seen a significant change, though, which I suppose is positive, is that as we have been dealing with such things as the long-term care issue and the advocacy issue, we have become more and more involved with coalitions of other disability groups, and I think within the disability community there is a much better understanding about just exactly why we as an organization always seem to be complaining. It's not a comfortable situation when you're always saying "but we are not happy," but I think many of the other disability groups are really understanding why we are not happy, and that is a positive step because at least we are in sync with them.

In terms of what is going to happen with this act, we certainly are very committed to the fact that there needs to be a structure and a system for advocacy for vulnerable people. There is no argument there. I hope that what finally gets royal assent, whenever it does, will be a little more responsive to the needs of our population, because it's a large population and it is an often forgotten and neglected population.



**Mr Gary Malkowski (York East):** I would just like to clarify it. You're talking about the learning disability organizations specifically, the consumers' organizations. Are you suggesting, then, that in section 15 they would be under the neurological grouping? Is that what learning disability groups want? Do they want to have members appointed to the Advocacy Commission coming under that category?

**Ms Nichols:** The primary thing in terms of section 15 would be if learning disabilities stood by themselves as a separate disability grouping, rather like it is in the Human Rights Code under the definition of "handicapped," where learning disability appears separately from other disabilities. That would be our number one choice, because I think it would really represent a level of visibility that learning disabilities don't currently have.

If, however, for some reason I don't know about, the number of categories of organizations has been limited to the number you already have there, then I think it would be more appropriately placed with neurological organizations.

I recognize that one of the downsides of that particular subsection is the differentiation between who the consumer is, and I'm assuming that's what you are really getting at: Would that in some way disfranchise the consumers? But I think that as an organization we are very well aware that our consumers are people with learning disabilities, and while we work a great deal with families because many of our consumers are children, we don't have any mistaken idea that somehow we have to speak on behalf of the consumers. The consumers certainly do speak on their own behalf and direct us accordingly.

**Mr Malkowski:** So is there actually a consumers' learning disabilities organization?

1050

**Ms Nichols:** No, there is not a separate organization. We have worked together simply because many of the needs are so unmet at the moment that there has not been the kind of separation there has been in some of the other disability areas. The Office for Disability Issues actually has just given us a grant to establish the beginnings of a separate consumer organization and that is about to happen, but in fact they may choose to continue with the single organization. That will be their choice.

**The Chair:** We have Ms Carter, Ms Akande and Mr Owens yet, so perhaps you could be very brief.

**Ms Jenny Carter (Peterborough):** Thank you for your constructive criticism of Bill 74, but I am concerned about this accusation that it's a bureaucracy. It seems to me that we have gone out of our way to make it as unbureaucratic as possible; for example, by having it under the Citizenship ministry rather than Health or Community and Social Services and by having this appointments advisory board which is going to consist of consumer representatives. You have also conceded that we need some sort of overall organization for advocacy. I'm just wondering if you could clarify a little bit what we could do to overcome that problem or what that problem really consists of.

**Ms Nichols:** I compared what I feared—because obviously I don't know how it's really going to be because we

don't have the regulations—what I see happening with OTAB, the Ontario Training and Adjustment Board project, which began as a way of responding to training needs. At the moment, looking at it from a community organization, all I see is the establishment of a great many boards and a great many things and most of our involvement so far has been to nominate people who then have been interviewed and that kind of thing.

At the moment, in spite of the fact that we have spent an inordinate amount of time responding to documents and going to meetings and being consulted, what we don't see yet in OTAB is how anybody who needs training is going to get money to get that training. I recognize that will come, but at the moment that is not obvious. It equally isn't obvious how Jobs Ontario will tie into that, and that may be because I have not seen the overall plan.

I'm merely alerting you to the concern many other organizations besides ours have. It is because advocacy is such an important thing for the kind of people we are, who we represent and work with that we would hope there would be as few boards, structures, processes and so on, and that as much of the very limited available resources would go into real services for the real people who desperately need it. So in a way I'm raising a problem which perhaps isn't quite there yet. I really just want you to be aware that we are very concerned in terms of what we see in some of the other areas and we hope it won't rub off.

**Ms Carter:** This is more a warning than a condemnation of what's there. Thank you.

**Ms Zanana L. Akande (St Andrew-St Patrick):** Your idea that learning disabilities should be included is an interesting one that I support. However, I also know that the identification of learning disabilities is often questionable and that it is actually—if you look at special education definitions—a definition by exclusion, a disability that is not caused by intellectual deficit, is not physical, so there isn't an actual formal pinpoint. Having been a consultant in that particular area, it is particularly interesting to me to know how you would have that designation assigned formally, by what assessment procedures. Whose would you have us accept?

**Ms Nichols:** The definition that the Ministry of Education has for learning disabilities has not been formally revised since 1984. In the past eight years, a great deal has happened in terms of research and our ability to identify. Certainly today you could, if you wanted to, use electroencephalograms and such things and identify learning disabilities. The last thing I want to suggest is that we go that route. All I'm saying is that Education's definition predated our capability in sort of medical ways of identifying.

I think that especially if in fact the vulnerable person will continue to be identified as the identified or perceived problem, then many of the much more informal structures for identifying learning disabilities, based on discrepancies rather than exclusions, would be beneficial.

I recognize that one of the big dilemmas we have faced and we continue to face is that the identification of children with learning disabilities so much reflects the person who is doing the identification rather than the child.



**Ms Akande:** And the class of the child.

**Ms Nichols:** Right. I certainly would not want to suggest that we remain with that situation. But in fact there are excellent interview-style assessment tools for adults that are being used and can be used, so that we don't have to have psychologists involved and we do not have to have medical examinations. I think that in fact those kinds of ways of identifying learning disabilities would work well.

It seems to me that many people want to eliminate the category of learning disabilities, because in so many cases it has been poorly used. It seems to me in that case it's really throwing the baby out with the bathwater, because indeed learning disabilities do exist, and they really are a difficulty. Just because many of our school systems have misused the terminology, it doesn't justify getting rid of it all together. I think there are good ways of identifying and defining learning disabilities these days which are not all exclusionary, because I grant you that the exclusion is a problem.

**Mr Stephen Owens (Scarborough Centre):** You brought up a really interesting point with respect to the employment relationship of the advocate in terms of the amount of time and money that would have to be spent by agencies like yours to supervise etc.

How do you view that employment relationship? Do you think the advocate should be employed by the agency that he or she is advocating against perhaps, or do you see the nature of the advocate's employment relationship needing to change?

**Ms Nichols:** It seems to me there may be a number of different ways that advocates can be employed. Certainly there are currently advocates who are employed by community agencies such as mine and they may indeed be advocating against that very organization or perhaps another branch of that same organization they work for.

It does not, as far as I can see, create a tremendously big problem while the choice of the advocate is the consumer's, if the consumer can decide who is the advocate. In the same way, if the advocates work for the commission and the commission is or is perceived to be a part of government, then all those advocacy issues that come up via the government and government services and government funding would also create a roadblock.

I would say the ideal situation is that the advocates work for community agencies and that the commission sets the guidelines but doesn't have them working directly for it. That is more for financial and reporting reasons than anything else. It just seems to me if the commission is going to have thousands upon thousands of advocates throughout the province working on its behalf and somebody's going to have to supervise them and so on, the finances related to that are tremendously costly.

**Mr Owens:** So in your view, you don't feel there might be either a conflict of interest or a perception on behalf of the clients that because the advocate works for the particular association which they may be having trouble or difficulty dealing with, that advocate would be perceived as being less effective. I guess the second part of that, in terms of the advocate's position, do you not feel he or she may be coerced—that's a strong word—into perhaps not advocating as strongly against his or her employer?

**Ms Nichols:** I think certainly the question of conflict of interest would have to be very carefully addressed, but the consumer who is using the services of that advocate would always have another choice, because I'm quite sure there will be advocates who will be with other organizations or in other circumstances, legal aid and that kind of thing. I would like to think that most non-profit organizations would not coerce their staff when their staff were doing the right job. More than that I can't say. Obviously it depends on the individual agency.

I think one of the guidelines the commission could in fact set down is that agencies have to come up with a structure for how the advocates are to function, how they are to be supervised and to what extent they have latitude in terms of advocating within that organization.

**The Chair:** Ms Nichols, Ms Lewis, on behalf of this committee, I'd like to thank you for taking the time this morning and giving us your presentation.

Just a reminder that we'll be having a subcommittee meeting right now and we will reconvene at 2 o'clock to discuss the subcommittee report. This committee stands recessed until 2 pm.

The committee recessed at 1102.



## AFTERNOON SITTING

The committee resumed at 1414.

## SUBCOMMITTEE REPORT

**The Chair:** I call this meeting back to order. First of all, we'll deal with the report of the subcommittee.

"Your subcommittee met on Thursday, 6 August 1992, and agreed to the following with respect to Bills 74, 108, 109 and 110:

"1. The committee will utilize the reprinted bills contained in proposed government amendments and deem these amendments moved.

"2. The clerk of the committee shall request the attendance of the ministers of Citizenship, Health and the Attorney General for the purpose of clause-by-clause on their specific bill(s).

"3. The bills shall be considered in the order that best accommodates the ministers' schedules.

"4. A maximum of two days clause-by-clause consideration shall be spent on each of Bills 74, 108 and 109. One day clause-by-clause consideration shall be spent on Bill 110.

"5. Votes on the individual sections and on the bills as a whole shall be stacked until following consideration of the final bill."

One thing I have to mention is that recommendation 1 has to be unanimous. Agreed? Agreed.

Would somebody care to move the subcommittee report?

**Mr Mark Morrow (Wentworth East):** I'll move that, Mr Chair.

**The Chair:** Mr Morrow moves the subcommittee report. Any discussion? Comments?

**Mrs Sullivan:** I'd like to emphasize that certainly the opposition parties feel very strongly that the ministers should be in attendance during clause-by-clause consideration. We have not had their presence other than at the opening addresses. While the parliamentary assistants are doing their work to the best of their ability, they have not been able to respond to the policy context. In fact, it's quite clear they don't have the authority to concur with amendments that are put forward from the opposition if those amendments are ones which could be accepted by the government. As a consequence, we feel that is a singularly important aspect of the subcommittee report.

**The Chair:** Further comments? Seeing no further comments, all those in favour? Opposed?

Motion agreed to.

**The Chair:** Our next presenters aren't here yet, so we will have a 10-minute recess.

The committee recessed at 1416.

1433

## PEOPLE FIRST OF ONTARIO

**The Chair:** I call this committee back to order. I'd like to call forward our next presenters, from People First of Ontario. Good afternoon. As you know, you'll be allowed a half-hour for your presentation. The committee

would appreciate it if you would keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Mr Patrick Worth:** I'm Patrick Worth, the past president of People First of Ontario.

**Ms Ann West:** I'm Ann West. I'm the vice-president of People First of Ontario.

**Ms Judith McGill:** I'm Judith McGill and I'm a part-time adviser to People First of Ontario.

**Mr Worth:** Thank you for inviting us here today. We appreciate being able to give you a chance to hear our point of view on advocacy and guardianship.

Before I get into that, I'd like to explain the role of our adviser. Judith McGill is here to support us in case we get stuck on things we're not sure about and to help us generally along with communication if we don't know where the communication is going at some times, and just generally to be supportive of People First members here.

We believe that the Advocacy Act should be a shared advocacy model. That means both paid and volunteer. It's very important to understand that we, as People First members, think a lot of people with disabilities have had nothing but paid people in our lives and we believe that volunteer advocates working with paid advocates make a better team. It assures the individual that advocacy will be a friend and that advocacy means that we are reaching out to people who have been left isolated and segregated for a long, long time.

We don't believe that advocacy, volunteer advocacy or paid advocacy, should be one versus the other. Both are equally important, and we recognize the fact that some people need to be paid to be advocates and we also recognize the fact that there need to be volunteers. There need to be people who are just willing to give their time to be advocates and to be a closer friend to the individual.

The emphasis must be on advocacy. Standing beside someone in a time of need is a very important thing, to make sure that the individual is not left alone or isolated or feeling that the individual is completely powerless. We feel that true advocacy means standing beside the individual no matter what the circumstances are, no matter how hard it gets, and maybe accepting a lot of criticism at times from people in society. But if we don't stand beside the people we say we advocate for, then we are not true advocates.

Helping a person find his voice is something that is extremely important to people who are vulnerable and never had a voice. I myself was once a person who didn't have a voice in society and people thought that I couldn't do things. People thought they had to make decisions for me. I wound up in segregated, isolated places. If people had recognized the need for me to have a voice a long time ago, maybe I wouldn't have been as wounded as I was in going through segregated workshops and segregated group homes and other segregated places. Most of our members



in People First are people who have had a life of segregation and isolation. Maybe if our members were people who were thought of as people who had the right to have a voice a long time ago, we wouldn't be sitting here right now speaking to you about the importance of having a voice.

We don't need any more people in our lives to control our lives. We need people to empower our lives. We feel that advocates who have the right kind of principles and the right kind of heart to get involved with people and recognize that people need friends, people need to be loved, people need to be nurtured in a true, meaningful relationship, that's how we empower the lives of people. That's how we make them less vulnerable.

It is important that an Advocacy Commission must be run by vulnerable people themselves, not service providers. We have had enough people in our lives who have controlled our lives. We must be able to set the destiny for teaching advocates how to advocate for us. We must be able to somehow reach out to people and be able to teach people, and maybe people will teach us, about how to advocate for the most vulnerable.

The independent advocacy system must be independent from the government and at the same time be supported by government. You are the people who control this province; you are the people who actually have a lot of say in what kind of politics go on and what kind of decisions are made. You are the leaders of this country and we feel that we have the right to expect you to support an independent advocacy system.

1440

It must not be something that is here today and gone tomorrow. We're in a world where we talk about cutbacks. We feel that this is something that must not be cut out of people's lives once it begins to operate. We feel that we must be able to count on the leaders of this country to make sure that once an advocacy system is set up, it is set up for good; it is a lifetime support, not a support that is going to be cut off some time down the road. People will be hurt again. People will lose trust in you again, and maybe that trust will never be restored after that.

We believe that an advisory committee made up of family members and service providers will increase the vulnerabilities of the commission members. This is an issue of who has the power to direct the work of the commission. The advisory committee should be made up of people who have demonstrated their commitment to advocacy; their powers must be limited to providing advice only.

We feel it is important that this committee be made up of people who are community advocates and people who generally might have some knowledge of how to advocate for people in the right way. We feel that this committee must be limited to only advising the commission, because the commission must have the power to decide what advocacy looks like. We're talking about a commission of people with disabilities having the power to empower us, the vulnerable people.

We support the amendment that will exclude community agencies offering services to contract with the Advocacy

Commission. We recognize this recent change and we appreciate it very much.

The Advocacy Act should only go through if it includes the right of all people labelled with disabilities. This is a fundamental right with People First of Ontario that we've taken position with. We believe that all people with disabilities, regardless of how they communicate, can communicate. We know there are people out there who people think can't communicate because they can't verbalize themselves physically, but we think it's time and it's important for people to recognize that we all have different communication skills.

Somebody who's biting their arms in an institution, in a back ward, can be saying to you: "I'm frustrated with this place. I'm frustrated with living here. Nobody's paying attention to me. I'm frustrated." People always take that as a violent act. Where people are abused every day of their lives, they also learn to abuse themselves because that's the only thing they have to do and that's the only reaction they ever get. Nobody ever pays any attention to them.

You can't tell me that if you were in the same circumstances, you wouldn't be doing the same thing, because you don't know that. We must not make judgements on people whom we think cannot speak for themselves or make decisions, because I think there is something inside all of us that gives us the skills to communicate and make decisions.

The most vulnerable people are the people in the most need of advocacy. We feel that the most vulnerable people generally are being left out of the Advocacy Act, and we don't feel that's right. People who have difficulty verbalizing themselves or trying to communicate their needs to someone must not be punished by leaving them out.

We must have the responsibility in trying to understand their communication, and that means a long-term commitment to developing a relationship with people who communicate differently from us, but nevertheless communicate. Their behaviour is not something that should be considered as violent. Their behaviour should be considered as trying to communicate, and we're not recognizing that.

Now I'm going to turn this over to Ann West.

**Ms West:** People First of Ontario believes that the proposed legislation for substitute decision-making discriminates against people who are deemed not able to speak for themselves. Under this legislation, people who are so labelled would be treated differently. They would essentially have their humanity taken away, because the process would involve being assessed as being incapable of making their own decisions, then legally being replaced by someone who is given the right to make decisions for you.

The right to make your own decisions is fundamental. We believe that it is a right that all human beings must exercise in order to be full citizens. Our movement exists because in the past society took away this right from many people labelled mentally handicapped. Sometimes this was done through a legal process, but often it occurred because of an assumption that all people who were labelled mentally handicapped were not capable.



One of the goals of People First of Ontario is to speak for ourselves and make our own decisions. We know that some people may need a considerable amount of support to do this, but the fact that one may need support must never result in that person being defined as incapable.

Now I will turn it over to Pat Worth.

**Mr Worth:** What are some ways of helping people to make decisions? We need to put in supports for people who need and want help making decisions. We must make sure that people have support in making decisions from partners they know well and trust. These partners then would interpret these needs and desires to others. Just like ramps and elevators are needed for people with physical disabilities, support is needed for people who need help in making decisions.

We all need help in making decisions sometimes. I don't think there's anybody in this room who entirely makes decisions on his or her own. We all need the interdependence, and it should be there for everybody. We should never have a separate law saying something different. We should never exclude people from the law. If we exclude people from the right of making decisions, then we exclude people from every practical need in society.

People First of Ontario believes that advocacy should be available to all people who are vulnerable, regardless of the disability or how severe the disability is. No one is completely without ability, and the law should guarantee the right for all people to use their abilities to contribute to decisions made about their lives.

No law should allow people to be legally replaced, as they would be under the Substitute Decisions Act. Powers of attorney should only be an option for people who can understand that by giving a power of attorney, they are choosing a substitute decision-maker. For people who don't speak for themselves, decision-making must be interpreted within trusting relationships, and it is essential for the law to meet this need. Doctors and other service providers may need protection, but this protection should not require taking away the rights of people who can't speak for themselves.

**The Chair:** Thank you. Questions or comments?

1450

**Mrs Sullivan:** I have a brief question in relation to the point Mr Worth made about supporting the removal of some non-profit community agencies with respect to the provision of advocacy services: subsection 7(2), page 6 of the bill.

You spoke positively in your opening remarks about the role of volunteers in providing advocacy services as well, along with the role of paid advocates. One of the things we've found interesting as we've been going through this act is that the intention is that the commission would have authority over all advocates, including specifying their training, their accountability and so on, through regulation.

One of the things that has concerned some of us as we've looked at the bill is that this particular section may well mean that certain agencies in certain communities which provide other services, perhaps group home services

or whatever, would be excluded from providing advocacy services with this provision in the bill.

I wonder if you think it's appropriate that this occur and why. Why should an agency that is community-based, that may be the only agency in an area providing those services, not also be able to provide advocacy services and be under the aegis of the commission in terms of the requirements for training and the accountability of the advocates?

**Mr Worth:** I do think the amendment is appropriate. The reason why I think this is clear to us and People First—group homes are still a segregated service. It's not independent; it is an agency that operates a segregated service.

We believe people who are segregated will always be vulnerable. We believe service providers provide an agency, but that doesn't necessarily mean advocacy all the time. It becomes a conflict sometimes. How can a service provider advocate for an individual and an agency? There are times when service providers run into tough battles when the agency disagrees.

There's also the fact that the service provider does have more power than the individual. You provide a service for people who are vulnerable, but you provide a segregated service. People who are vulnerable are voicing their feelings about going out to work, going out into community homes and going out into their neighbourhoods, places where we want to be with family members, neighbours and people we get to know just naturally.

It doesn't happen naturally in group homes. Group homes are restricted places. I lived in a group home. I was told when to go to bed, when to get up, what to eat. I had to go to a sheltered workshop, I had no choice in that, and I was very poor. I didn't have a choice.

**Ms McGill:** I'd like to ask you a question, Pat. Do you believe an organization that runs sheltered workshops, sheltered residential services and services in general can also do advocacy? That seems fundamental to what you're asking.

**Mr Worth:** It can do advocacy sometimes, but I don't see how it can be a part of the independent advocacy system, because this advocacy system is about empowering the powerless. It's an independent system that is set up for people with disabilities to have a chance to have their say in advocacy and be able to run an independent system so that advocacy is independent.

**Ms McGill:** Is a person working in a sheltered workshop likely to go to the sheltered workshop employer and talk about the difficulties in his life at that sheltered workshop?

**Mr Worth:** No. Most of them I know are too afraid.

**Ms McGill:** So that's part of the issue.

**Mr Jim Wilson:** I think part of your concern, if I got it correct, was that perhaps improper assessments will be done or that an assessor may deem someone incapable improperly, simply because the assessor doesn't understand the communication of the person. First of all, tell me if that was part of the concern. Second, how can we, through this legislation, improve upon that? The way it's



left now, as you know, the qualifications and process that an assessor will use are being left to the regulations.

**Mr Worth:** I'm not sure what the question was.

**Mr Jim Wilson:** I wrote down here that people most vulnerable, first of all, may be left out of the Advocacy Commission; ie, those not able to speak for themselves may at times be assessed incapable, when in fact they're capable. I can see the problem. Part of the problem is, I think, that it's not spelled out very clearly here exactly who these assessors are and how they go about making their assessments.

**Ms McGill:** Do you understand the question?

**Mr Jim Wilson:** I'm sorry. It's the way I am phrasing it.

**Ms McGill:** Maybe I can try to rephrase that. You're asking whether or not People First of Ontario believes there is a problem in how people are—

**Mr Jim Wilson:** Assessed.

**Ms McGill:** How the decision is made about who is deemed incapable of making their own decisions. Is that an issue for People First, about how it's decided who can make decisions for themselves?

**Mr Worth:** I think the issue with People First is that we know there are people who think there are people who cannot make decisions and cannot communicate. I think our message here is that everybody can communicate. Everybody has a skill to communicate; if not verbally, then in some other ways. We just don't listen. We need to listen harder to people who are trying their best to communicate and are trying to say they're frustrated.

We need to feel for a lot of people we are talking about, people who cannot verbalize themselves, people who have trouble communicating their feelings to people. I think part of the problem is that we don't listen to their feelings. We think they cannot communicate, so we just don't communicate with them. We make the decision they can't communicate, that they can't decide.

**Ms McGill:** So would People First of Ontario want someone to assess someone as being incapable of making a decision?

**Mr Worth:** No. We don't need any more labels. We have had enough labels, and legally deciding that people are mentally incapable just lowers their self-esteem. It makes them feel they can't do anything. It doesn't make them feel good about themselves.

**Mr Jim Wilson:** For the advocates to be called in, there is a requirement in this legislation that they be deemed incapable, that at least there be a question of their ability to communicate, as it were.

**Mr Worth:** Yes. We disagree with that requirement.

1500

**Ms McGill:** Maybe I can clarify that, as it relates to substitute decision-making. Is that what you're referring to, Mr Wilson?

**Mr Jim Wilson:** Yes. So specifically in substitute decision-making, okay, you can see it. I understand.

**The Chair:** We have three questioners—Ms Carter, Mr Owens and Ms Akande—so perhaps you'd be brief.

**Ms Carter:** I agree pretty well with all that Patrick Worth has said about what should happen. The difference is that I believe Bill 74 does meet those requirements almost as far as is humanly possible.

First of all, it's not just paid advocates that we're looking at. The bill does specifically say that volunteers will continue. If you want to look at that, that's on page 21, subsection 34.1(3): "Nothing in this act prevents a person who is not authorized under subsection 7(4) from providing advocacy services, as long as the person does not purport to provide the services on behalf of the commission."

In addition to that, people who work for volunteer community agencies can function on behalf of the commission, so we have every possible means of incorporating volunteers, and really the paid advocates are just going to be a kind of last resort. We've been told there will probably be only about 150 of them in the province so what they're really doing is bringing a kind of expert backup.

It's also important that because we will have the commission and the advocates, we also have the powers that are granted to them, so they can get access to people and they can look at records and so on. It's that kind of thing we're doing in this act, trying to empower those who are helping the vulnerable. That's really what we all want.

Also, I think there is provision here for making sure that communication will be made with a vulnerable person if it is possible. That means leaving no stone unturned to find out what this person really does or doesn't want. So the question of uninstructed advocacy becomes relevant only when you're looking at somebody who is totally incapable of communicating. You've told us, and I think we believe it, that there are very few people to whom that applies. I'm just wondering what we need to do to the act to accommodate what you're saying, because it seems to me that we do agree pretty well already.

**Mr Worth:** The Advocacy Act very severely limits people who have problems with communication and have to communicate differently. You put limitations on those people. Their rights to an advocate must be respected as much as somebody who can verbalize.

**Ms Carter:** As I say, I think every effort will be made. If people communicate just by blinking their eyes or something, still they can express an opinion.

**Ms McGill:** A clarification on that, Pat: Ms Carter asked if there is anything in the bill that People First of Ontario would like to get rid of entirely. Your position on the substitute decision-making aspect of the bill has been outlined. I think that might be—

**Mr Worth:** Yes, that part I would like to see dropped.

**Mr Owens:** I would like to start with a comment and then a question to either ministry staff or to the parliamentary assistant. Mr Worth, in terms of your comments with respect to advocacy being provided by the service provider, I can't agree with you strongly enough that I think there's an inherent conflict for those employed by an agency advocating for individuals who are either resident in that agency or employed by that agency.

No matter how well meaning people want to be, there is a potential for conflict. If we look to associations like



the Adult Protective Service Association of Ontario, I'm sure they can provide us with a litany of difficulties they've had with their advocates advocating against the person who signs their paycheques.

I take to heart your comments with respect to cutbacks and the fact that all the politicians sitting around this room will at some point in their careers cease being politicians in elected positions. But people like yourself and Ms West will continue to have to live within the system and it is clearly inappropriate to set up a system and leave groups like yourselves hanging.

My question, to either the parliamentary assistant or to the ministry staff, is with respect to individuals who are non-verbal. Is there a presumption made that these individuals are incapable and what kinds of steps are in the process of being taken to ensure that these individuals' rights are going to be protected, as capable people's rights appear to be, within this legislation? What's currently being worked on?

**Mr Malkowski:** I'd like to refer this to Mary Beth.

**Ms Valentine:** The section in the act that I think would most specifically address that is subsection 15.1(3), the clause that basically states that the advocate is not in any way to take any action unless every effort has been made—"all reasonable steps" is the phrase—to determine whether the vulnerable person is incapable.

The issue of communication is definitely being addressed from the standpoint of accommodation. In looking at this type of service, being again disability legislation, the issue of accommodation for persons with all different types of ability has to be very clearly addressed, both in considering funding and training and considering the types of service and equipment requirements that will be available. There would be the expectation that if there was an interpreter required, a Bliss board required or whatever the situation was, there would be every onus placed on the advocate.

**Mr Worth:** The point about assessment is that we don't feel people should have to submit themselves to an assessment to ensure that they get advocates or not. This goes back to the whole assumption that someone's mentally incapable and you're missing the point. We're saying that every person has a gift, every person has an ability and every person has an ability to communicate in some way. I'm simply saying that an assessment is not a way of listening to people; an assessment is a way of judging people.

**Ms Valentine:** Could I clarify? There's no assessment required to obtain an advocate. The issue is one where perhaps if we think of someone who has been in a car accident and is completely unconscious, completely incapable of communicating in any way, that person may well require advocacy under a certain circumstance, or there may be very specific situations under very limited circumstances where someone is unable to communicate.

You may want to address that further, Patrick, but that is where the intent is and it does not require an assessment. It requires an onus on an advocate to do everything possible to try to get instructions from the person. It's not an assessment of whether the person is capable or not; it's whether the advocate can find out what the person wishes him to do.

1510

**Ms McGill:** I have a question at this point in relation to the serious harm section where access to advocacy has to do with whether or not an advocate can determine that the person either is directly in serious harm or is apt to be in serious harm, because there are restrictions on whether someone is deemed not to be able to speak on his own behalf and on his access to the advocacy provisions, are there not?

**Ms Valentine:** Yes. The issue there again is a restriction on the advocate, that the advocate is only able to act in a situation where there is a risk of serious harm to the health or safety of the person and is not able to get instructions from the person. Only under those circumstances is an advocate able to act without instructions.

**Mr Worth:** But that was saying that the person's life has to be in jeopardy first.

**Ms Valentine:** A risk of health or safety is what it says.

**Mr Worth:** That's what we don't agree with.

**The Chair:** Time's up. We have other presenters waiting right now.

**Ms Akande:** I think it's an important point. If you would bear with me to make one—

**The Chair:** Very briefly.

**Ms Akande:** I think one of the things we haven't differentiated, and I know that Ms Carter referred to it, is that there are really two levels of advocacy. There is primary advocacy to which all associations would subscribe—people, neighbours, family—and then there's the advocacy of last resort around which we have fashioned this legislation.

No one is suggesting through this legislation that any of that primary advocacy would be denied or restricted to any individuals who required it, and so all individuals would have access to advocacy at all levels. The only thing we have designed legislation around is for making sure that there are provisions for situations of last resort.

**The Chair:** Mr Worth, Ms West, Ms McGill, on behalf of this committee, I'd like to thank you for taking the time out this afternoon and giving us your presentation.

**Ms McGill:** There are copies of the brief if you want to pass them around.

#### ONTARIO ADVOCACY COALITION

**The Chair:** I'd like to call forward our next presenters from the Ontario Advocacy Coalition. A reminder that you will be allowed a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions or comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and proceed.

**Ms Joan Fussel:** Thank you very much for inviting us back today to discuss the amendments to these bills. I'm Joan Fussel. I'm co-chair of the Ontario Advocacy Coalition on which I represent Concerned Friends of Ontario Citizens in Care Facilities. With me are David Giuffrida, who is the acting coordinator of the psychiatric patient advocate office—he will primarily address the Consent to



Treatment Act—and David Baker, executive director of the Advocacy Resource Centre for the Handicapped. He will primarily address the Substitute Decisions Act and I will address the Advocacy Act.

I'd like to point out to you before we get into the substance of the bills that the Ontario Advocacy Coalition represents 30 member organizations across the province. Among our organizations, we have organizations which represent each of the categories that are mentioned in the Advocacy Act.

We feel it's fair to say that the Ontario Advocacy Coalition, because it's so broadly based, is as close as you can come to representing the community at large of vulnerable people who will be affected by all these bills.

Personally, I am a family member of someone who was in a nursing home. I'm not a lawyer. I'm an ordinary person, though my colleagues are lawyers whom I've invited because of the technicalities of Bills 108 and 109. I'd like you to know that most of the members of the coalition are not lawyers; they're ordinary people. Many of them are people who themselves have disabilities.

I'd like to commend the government and the people working within all the sponsoring ministries for the great effort they have made to listen to the different points of view that were presented to you in the first round of public hearings. I think they've made a tremendous effort to take all those into consideration, to balance them and to make some positive changes in all the bills.

I also want to thank and commend all three political parties for your cooperation with each other in agreeing to proceed with the bills—because I know that was in question at one time—and to work together. I hope and trust that will continue.

The coalition feels particularly strongly, as we have all along, about the Advocacy Act. It is the central issue which caused our formation. There have been some criticisms of the Advocacy Act in the press over several months in the past. It's been discouraging to read them because, almost without exception, they've been based on misrepresentations of what was in the legislation.

The act is innovative, and it's understandable that some will feel threatened by it and find it difficult to comprehend its basic element of empowerment of vulnerable people. It's legislation that's very badly needed and it deserves to be subjected to well-informed and well-intentioned scrutiny to ensure that in its final form, on third reading, it will have the best possible chance of fulfilling its purposes.

Within the act itself, we're particularly pleased that the issue of conflict of interest between service providers and the advocacy system has been addressed. A new concern we have is about the advisory committee of family members and service workers.

This is obviously a very fair intention to address concerns of family organizations and service providers. We can accept it, but we have in juxtaposition with that some very grave concerns over what was left in the bill, which was the exception concerning organizations to be involved in the appointments advisory committee process, the exception being organizations representing people with neurological disabilities.

Those organizations, as the bill is now written, do not have to consist of a majority of people with neurological disabilities. All the other types of organizations, the other categories, have to represent the people themselves, and that exception still stands.

Frankly, it isn't fair. It isn't fair to the other categories where people are speaking for themselves. It isn't promoting self-advocacy. It is allowing well-intentioned family members to continue to speak for people with neurological disabilities when they obviously have advocates in that that they have their family members. It's other people who do not have family members to speak for them who will not be represented by those organizations.

We feel that you've made a very fair concession to your detractors by adding the advisory committee of families and service providers, and it is certainly not necessary and not acceptable to keep this additional concession to people concerned about family members with neurological disabilities. You should let the people with the disabilities speak for themselves.

#### 1520

Another issue concerns non-instructed advocacy. Several amendments were introduced to Bill 74 with the intention of extending advocacy in certain circumstances to persons who are deemed incapable of instructing an advocate. These amendments authorize an advocate to act in such situations, but only "if there is a risk of serious harm to the health or safety" of those persons.

We believe this is too restrictive. It's unacceptable to create a legislative scheme in which the most vulnerable persons of all will not be entitled to the full scope of the assistance an advocate can offer.

These amendments will mean that an advocate will be unable to do anything for a person who is suffering harm that does not appear to be serious until the point is reached at which the threat to the person's physical wellbeing does become serious. Any concerned person should be entitled to intervene in order to rescue a vulnerable person from situations in which he or she is experiencing or will likely experience serious harm.

Where such a situation becomes known to an advocate, the peril the person is in is tantamount to instructions to the advocate to act on that person's behalf. Also, as you know, often instructions can be determined in non-verbal ways. An advocate should be able to act on those instructions as well.

To move on to the question of an additional member for the appointments advisory committee, this again directly addresses one of the amendments brought forward by the government. There is an attempt to produce a balance by giving the Minister of Citizenship the authority to name three members of the appointments advisory committee rather than two, as the original bill read.

This amendment was apparently introduced to the bill in order to ensure that the appointments advisory committee will have an odd number of members and will consequently not find itself deadlocked, but we think this tie-breaking additional member should be another senior. There is a preponderance of organizations representing various types of disabilities, and we've no objection to



that, but the balance and the tie-breaking should be done by the addition of another senior to represent more equitably the large seniors population in Ontario.

In our brief you can read a detailed amendment concerning access to information. The gist of this is that there should be broader access to information for advocates, that they not just be specifically allowed to see information about that one person, but also have access to policy manuals and incident reports.

It's also important that the advocate have access to information about a third party that directly concerns the person for whom they're advocating. For example, in an institution there could be an assault upon an individual, and it would be important for that individual that the advocate have access to a report which may name that person who made the assault.

The details, of course, of our concerns about these amendments are contained in the brief, which you all have before you. I think now it would be best for time that we move on, and I'll ask David Baker to discuss with you the Substitute Decisions Act.

**Mr David Baker:** As was said about Bill 74, it's the position of the Ontario Advocacy Coalition that most of the changes which have been made to the legislation as a result of the initial hearing process have been positive changes and they have the support of the Ontario Advocacy Coalition.

I point out to you—and you've just heard from People First, so you know it as well as we do—that there are not only concerns from the professional interests and a relatively small group of family organizations about the legislation, from one perspective—you can say on one side of the spectrum—but there are also major concerns being expressed from a number of organizations, some of which were formerly members of the Ontario Advocacy Coalition, from another perspective; namely, they're taking the position that this legislation is far too intrusive and goes too far in taking away the rights of disabled people.

As I say, you've just heard from People First. Patrick Worth, from whom you heard, was our co-chair up until July 31, so I think it's important to understand that there are many perspectives. We are hearing within our own coalition the perspective of People First, and I think in many ways it's beneficial for you and perhaps for us as well that you're hearing that perspective, because it needs to be heard.

Having said that, let me say that our major concern with respect to Bill 108 is that it potentially will be too intrusive, and by that we mean that too many people will be found to be incapable under this legislation. Our major concern with this legislation is that steps be taken to prevent that from happening. If there is any way we can be clearer about our objectives, we should do that.

I heard Mrs Carter say it was the intention to ensure that a very small group of people be found to be incapable. If that is the case, then we are suggesting at page 12 of our brief that we revisit an issue which was raised initially with you, and that is the standard of proof in this legislation. What we are saying is that if you cannot be absolutely certain that a person is incapable beyond a reasonable

doubt, then we should not be taking away a person's rights; we should not be finding him to be incapable. The requirement that there be proof beyond a reasonable doubt currently exists in the Mental Incompetency Act and is applied in a vast majority of cases where the issue comes before a judge.

I had experience with this issue in a piece of litigation which I mentioned to the committee on a former occasion, the Justin Clark case, where this issue of standard of proof was not proof beyond a reasonable doubt in the case in which I had to argue. I felt that case would never have gone to court if the issue had been proof beyond a reasonable doubt. It should never have gone to court and we shouldn't allow cases where there is a reasonable doubt to go anywhere near a court.

We should be clear about it, and we should be able to tell people like Patrick Worth that there are not going to be members of his organization yanked before a court in circumstances where there is not clear evidence that goes beyond a reasonable doubt in being satisfactory to a court. That position should be clear in the legislation and it should have always been clear in this legislation.

There are a number of other issues we'd like to touch on briefly.

In this legislation and in the consent to treatment legislation, there is the issue of the definition of "spouse." Currently, that would include an estranged spouse, so a situation could arise where an estranged spouse who has been in some dispute, has perhaps been abusive of the person whose capacity has been removed, will be introduced as the substitute decision-maker.

It is our position that as is the case with "others" under the legislation, there be some test. We suggest that the person be currently living with the individual, that that be the criterion which would be added to define "spouse" so as to deal with this particular issue. It is not a theoretical issue. It is something which arises on regular occasions now under the current legislation.

I'm at page 7 now and discussing the issue of the public guardian and trustee as statutory guardian of property.

Essentially, what has been done in Bill 108 is to create a comprehensive, fair mechanism for dealing with people who are unable to deal with their property. Unfortunately, to this point in time the government has chosen to leave the unsatisfactory and discriminatory informal process under the Mental Health Act as applying to people who are in a psychiatric facility.

It is our position that there is no justification for denying psychiatric patients the same procedural protections available to all other incapable people in Ontario. The mechanisms are there in Bill 108 which would satisfactorily address the needs of people in this situation.

1530

At the bottom of the page we point out—and this is again consistent with what I was saying about our concern that this legislation only be used as an absolute last resort. In our initial presentation to you we had called upon you to do away with the concept of partial guardianship because we were concerned that concept would be used to include a greater number of people under this legislation.



We have, again consistent with our goal to minimize the number of people who are found to be incapable, decided to recommend to you that greater particularity be used when identifying exactly what incapacity it is which is being referred to.

Halfway down page 8, there is the issue of the guardian's authority to admit a person to a psychiatric facility. We are concerned that the provisions of the Mental Health Act governing involuntary admission to a psychiatric facility and all the procedural safeguards which are set up to deal with involuntary admission will be circumvented through the too casual application of the substitute decisions legislation. It's our position that the provisions of the Mental Health Act are adequate and sufficient for dealing with this issue. Our concern in particular is that there will in fact be a significantly higher number of people who are found to be incapable as a result of this legislation. That we recognize as being inevitable.

Our concern is that the current application of the Mental Health Act results in virtually no one being involuntarily admitted by a person's guardian. We are concerned that there will be a significantly larger number of guardians of the person under this legislation, with the result that there will be a significantly higher number of involuntary admissions to psychiatric facilities than is currently the case. We feel it's inappropriate because the Mental Health Act provisions comprehensively should govern in these circumstances.

Page 9, the issue of cattle prods: The time does not permit to go into great detail about this issue. We feel it should suffice to say that Ontario is the only jurisdiction in the country which continues to permit professionals to use cattle prods for aversive conditioning. It has consistently been our position throughout that this is an outmoded mechanism which should not be permitted and in particular should not be legitimized with specific reference in this legislation, albeit an attempt to control the use of cattle prods. We urge the government to reconsider its decision to permit this to go on in Ontario.

On page 10, the issue is restraint and seclusion. We are concerned that the substitute decisions legislation will have application in settings where there are not safeguards in place as there currently are under, for example, the Mental Health Act, which is currently virtually the only place where you find restraints and seclusion being used. If you like, these decisions will be made in people's homes and in communities. People may be restrained and secluded in circumstances in which they currently cannot be, nor should they be.

We feel at a minimum it should be mandatory that when this power is being used a written report be filed stating that these restraints are being used, where they're being used and why they're being used so that there is some mechanism for overseeing the use of this power.

The issue of electroshock as opposed to electroconvulsive therapy, at the bottom of page 10, I think is a simple point of clarification which I would hope the government would have no objection to making. Clearly it is not the government's intention that ECT be used as aversive and circumventing in that way the application of the Mental

Health Act. However, some people feel it's important to make that explicit. I would hope that could be done.

On page 11, halfway down, the one change that we felt was a serious step backwards in the legislation was the decision to omit what was formerly paragraph 63(3)6, which stated that it is the responsibility of the guardian to take the person's current wishes into consideration if they can be ascertained. We don't feel it's too much to ask of a guardian that there be that degree of human interchange between two individuals.

I can tell you, because I've argued this issue in court as well, that there is case law to the effect that a person's current wishes are to be taken into account by the guardian. For the benefit of the lawyers present, it's a case called *West v West* out of New Brunswick. It's an important issue. The effect of having had this paragraph in the legislation and then removing it—again from a technical, legal standpoint—is to overrule the application of that particular case in this province, and I think that's precisely the wrong direction to be going in. I would ask you to put the paragraph back in.

At the bottom of page 11, the need for the public guardian and trustee to produce guardianship plans: Basically the issue here is that all guardians are required to produce plans as to what it is they're going to do with their authority as guardians and tell the court what it is they intend to do. An exception is made for the public guardian and trustee who is presumably seen as being infallible.

Those of us who have had dealings with the public guardian and trustee, particularly in years past, have unfortunately found that to be far from the truth. We ask that the plan be produced, because that is the only way in which the public guardian can be held accountable for the way in which he or she exercises the authority of that office over an individual.

I turn to page 12, to the issue of proof beyond a reasonable doubt. I would ask, if you feel at all responsive to the issues raised by Patrick Worth, that you consider this as the least we can do in order to assure him and to make clear what our intentions are in this legislation. We state that if it's not an open-and-shut case, it should never go anywhere near the court. We should not be tampering with people's very fundamental rights as individuals. I believe Ann West said it involves taking away a person's humanity. That's how serious it is to make this kind of decision about somebody. If we can't be sure about it, we shouldn't start that kind of process.

Now David Giuffrida will address Bill 109.

**Mr David Giuffrida:** I'm aware that time is short. I propose in the interests of time not to address each of the items listed in the portion of our written presentation beginning on page 12, but of course I'm willing to respond to questions about them if you wish.

I want to address my comments first to the point about the definition of treatment, in the middle of page 13. Section 2 of the Consent to Treatment Act says that the act "applies in respect of treatment," which is a defined term, "administered by health practitioners," which is a defined term. As goes the definition of "treatment," so we really define the scope and application of the act.



There has been a lot of fine-tuning of the legislation to ensure that the kinds of due process protections it provides are proportional to the invasiveness of the clinical intervention. We don't need a rights adviser visit if someone is having a bandage changed, for example. That scenario doesn't please anyone.

The proposal before you today is that the definition of "treatment" be essentially confined to the definition of "controlled act" under the Regulated Health Professions Act, plus behaviour modification. The consequence that would flow from that is that the due process protections in the Consent to Treatment Act would only apply to the more invasive sorts of interventions that are enumerated in the list of controlled acts under the RHPA. They include inserting a hand or instrument into an opening in the body, setting a bone, drawing a blood sample etc.

It's our intention—I hope this might be one that is positively received by health care providers as well—that we achieve some proportionality here and that the interventions, like a visit by a rights adviser, are limited to those situations where it is a controlled act happening within an institutional setting, the setting in which there is more potential for coercion.

Putting a time limit on substitute consent to treatment: We feel strongly that someone who is acting as a substitute decider in respect of an incapable person be in touch with that person, hopefully dropping in on him, seeing how he is responding to the treatment. What we would not like to see is someone who gives consent over the telephone in January and is not heard from again for the next 12 months.

The office of the official guardian, when it is called upon to give substitute consent to treatment under existing legislation, typically gives it for a maximum of three months. Then it wants to hear back how the person's doing. That seems like common sense and we'd like to see consent by substitutes limited to three months.

Seven-day delay before treatment is administered: For people who might have the misperception that those of us who work for patients' rights are exclusively trying to concoct ways of keeping treatment from people, I want to point out that three of the points I'm going to be speaking to you about are ones which could result in people getting treatment who would not get treatment as the act is now worded.

For example, in several places in the legislation, if a person is determined treatment-incompetent and just suggests that he might be considering applying to the review board to review it, the provider has to back off for seven days before the treatment can start. We think that's too long. If the person says, "I'm thinking of applying to the review board," we think a rights adviser should show up and assist him to apply if he wishes to apply. If he doesn't apply, he has 24 hours and then treatment can begin. We think that's more efficient.

The need for substitutes to have personal contact with the patient. That's something I've addressed. We don't think it's sufficient if there's just telephone contact or someone who hasn't heard from the patient in years is contacted from another province. They should be more actively involved.

Suspension of treatment pending an application to the review board. Again, the existing provision in the Mental Health Act is quite inflexible. If patients apply to the review board to review a determination of treatment incompetence, they can't get any treatment, even treatment they'd very much like to have. Sometimes that means they've deteriorated mentally to the point that they cannot present themselves in the best fashion at the review board hearing. We think if the provider wishes to provide the treatment, if the patient wishes to have it and the person who would be the substitute wishes to consent to it, they should have that treatment during that interim period.

Who may apply to the review board for directions? Wishes expressed when competent are pivotal in determining whether there will be consent or refusal by a substitute.

**The Chair:** Excuse me, could we have a five-minute recess while we fix up the sound system? This committee will stand recessed for five minutes.

The committee recessed at 1543.

1551

**The Chair:** I call this meeting back to order. Our apologies, Mr Giuffrida. Perhaps you could read your recommendations where we lost you, I believe, and then continue on.

**Mr Giuffrida:** Thank you, Mr Cooper. I am loathe to subject the committee to another summer rerun. I'm going to summarize what I've said to date, maybe even with minor variations.

Beginning on page 14, it is our recommendation, as shown in the middle of the page, that a time limit be put on substitute consent to treatment of three months, so that there's an obligation that the health care provider check back with the substitute decision-makers and make them aware of the health state of the person on whose behalf they are giving the consent.

I'd like to draw the committee's attention to two points at the top of page 15. In clause 5(2)(a) there is a fairly exhaustive list of the ingredients of informed consent, but conspicuously absent is the obligation on the provider to tell you what's wrong with you. We think that in that list you should have the phrase "the nature of the health problem."

Down to the next paragraph, subsection 5(3) says that consent may be "express or implied." This indeed is true, but out of context it could be an invitation to ignore the requirements of voluntariness and informed consent. I think it should better read, "Voluntary, informed consent to treatment may be express or implied." It is only a point of clarification of assertions made elsewhere in the legislation.

Turning to about the middle of page 16, seven-day delay before treatment is administered, we believe that the mandatory seven-day suspension of treatment when a person indicates a wish to apply to the review board is too long, and provided he has the opportunity to confer with his rights adviser and get assistance in completing the application form, he should be given 24 hours after that point to make up his mind and then treatment can begin if he doesn't apply.

In the middle of page 17, the need for substitutes to have personal contact with the patient: We would require



the substitute to indicate that during the last year "he or she has had ongoing personal communication with the person to the extent their respective abilities permit." Our wording is carefully chosen here, because we're sensitive to the fact that there might be an elderly couple where the husband is in a nursing home and the wife might find it difficult to travel 60 kilometres to visit with him. She is as involved in his life as her and his abilities permit and we would honour that kind of relationship and permit her to be the substitute. But if it's someone who just can't get around the corner to see a loved one in a nursing home, we don't think he should be the substitute.

Page 18, suspension of treatment pending an application to the review board: This recommendation arises out of real situations that have come to my attention in the Psychiatric Patient Advocate Office where a patient says: "I wish to review the determination of incompetence, because I don't believe I'm incompetent. However, I do wish to take the treatment, but I can't get it if I beg for it, because the act says 'Treatment shall be suspended.'" We want to introduce some flexibility there.

Turning to page 21, who may apply to the board for directions, a lot turns on what wishes a now incapable person expressed about treatment on a prior occasion when competent. It would be wonderful if everyone reduced these wishes to writing and had it signed and witnessed and we had that kind of clarity. That isn't the reality. It won't be the reality.

There are going to be people who bring their best abilities to trying to figure out what weight to assign a statement that was made by a person two years ago about a certain kind of intervention. We think the provision that now exists in the act that allows the substitute decider to apply to the review board to get some guidance, some clarification, is a good one. Our concern is that sometimes the substitute may feel that the prior wishes are abundantly clear, but someone else doesn't, and he is the only person authorized to apply to the review board. We think, for example, that the patient should be able to apply and the public guardian and trustee as well.

We are aware of situations where people are untreated now, perhaps in seclusion, seriously disordered. This is ostensibly because the substitute is carrying out prior wishes expressed when competent, where the health care providers may seriously question whether that was a competent wish. Under our proposed amendment, if the health care providers are able to persuade the public guardian and trustee that there really is some serious doubt here, the public guardian and trustee could initiate an application to the review board. There could be a review by that board expeditiously about what those wishes were and they could give some guidance.

Let me turn to the bottom of page 23, professional background of the public guardian and trustee under Bill 110: We have noted that there's a requirement that the PG&T be a lawyer of ten-year standing. We cannot understand why that's a requirement. We can understand why there are many qualities the person holding that important position should have, including a very clear and profound understanding of the lives of vulnerable people and how

best they can be empowered. We don't see that the person in that position be a lawyer.

Turning now to the bottom of page 22, in contrast, we do see a role for lawyers as chairs and vice-chairs of the Consent and Capacity Review Board. There are many technical decisions to be made by the person in that role. He or she must make decisions about burden of proof, onus of proof, who has party status, what documents are admissible etc.

The personal issues can be very strong. There can be a temptation to override the technicalities of the law because of the personal issues. We're concerned that will lead to decisions built on sand.

**The Chair:** My apologies again; we're down for another couple of minutes. We will have a couple of minutes of recess.

The committee recessed at 1558.

1605

**The Chair:** I'd like to call this meeting back to order. Once again, my apologies for the breakdowns. Mr Giuffrida, if you'd please proceed. Order, please.

**Mr Giuffrida:** Thank you. I was trying to guesstimate at one point when we most recently experienced technical difficulties—at the top of page 21, I was pointing out the benefits of expanding, in section 28, the scope of who may be permitted to apply to the board to have a review of what the allegedly competent wishes expressed in the past were.

We think this is an important provision in situations where, in particular, a person is not being treated and the substitute believes it is based on wishes expressed while competent, but other people in the incapable person's life, who may have heard other utterances at different times, may not be as convinced that the utterances that the substitute is relying on were made during a time when the person was competent etc.

As the legislation stands now, the only avenue available to people who feel that the substitute is not accurately interpreting competent wishes is to apply under the Substitute Decisions Act to have the substitute removed. That's quite a significant and, one could say, aggressive act, and I wouldn't expect substitutes to be removed unless it could be shown that they were acting in bad faith or with significant incompetence. We think this could be a very convenient intermediate step, to have a review at the board to clarify prior wishes.

I was then talking about where it is and is not important to have lawyers in the system, stressing that for the public guardian and trustee, it did not appear important to the coalition that that person be a lawyer, whereas for chairs and vice-chairs of the Consent and Capacity Review Board, it did seem quite important.

My point is that, among other problems with having people governing the process of the board who might not have expertise in the processes of administrative tribunals, their decisions, while perhaps sound on the merits, might be built on sand. Technically, they may not have followed due process and may in fact give one or the other party grounds to appeal. There could be more appeals resulting from making wrong calls on process in the first place. As a



rule, appeals will take some time, and as a rule, treatment will be suspended pending the appeal. So there are any number of reasons why it would be better to have the people in place who can make those calls correctly in the first place.

Finally, on page 24, the suggestion in the middle of the page under "Authority of the Mental Health Review Board to order transfers" also relates to a provision that would allow the Consent and Capacity Review Board to review the decision of a substitute to authorize the admission of a person to a psychiatric facility. As David Baker has pointed out, we don't believe, as a rule, that a substitute decider ought to have the authority to compel someone to come to a psychiatric facility.

Our point is that too often in reviewing civil commitment, the review board, under the existing legislation and under the Mental Health Act, has to decide whether the person can be released to the street or retained in exactly the same setting that he is in now, an institutional setting. The review board may be of the opinion that the person is in too restrictive a setting. It might be a double-locked ward, for example, or he may have very few privileges. However, if they conclude that it would be irresponsible to discharge the person directly to the street, they can do nothing but confirm the certificate and maybe make some obiter, non-binding comments in the decision.

We think it would be a useful improvement to give the review board some more refined tools than the simple ones they have now: either lift the certificate or confirm the certificate. With the blunt instrument they have now, they can only but confirm the certificate 85% of the time. We'd like to see the Mental Health Act amended to give them the opportunity and circumstances they deem appropriate to say, "This person's not yet ready for the community but doesn't need to be in as restrictive a setting in that hospital as he now is," and to give effect to that.

Trusting in the technology to prevail, I'm going to pause there and give you an opportunity for questions.

**The Chair:** Thank you very much. Mr Kwinter?

**Mr Kwinter:** I have a question, and it has to do with one of your recommendations at the top of page 7 dealing with changing clause (a), the definition of a spouse. I appreciate the rationale, given the example you use. I want to give you the other side of the coin and I just want to get your response on how you deal with it.

Let's say we have a spouse and one of the partners is confined to an institution and has been for years. They still have a relationship. That spouse, for whatever reason and whatever his or her illness is, has to be institutionalized. Under your recommended amendment, that couple, by no stretch of the imagination, legally or in reality, have been living together. Would that in fact remove the ability of that spouse to make decisions on behalf of the partner who is in the institution?

**Mr Baker:** You may be aware that under the Divorce Act the issue of separation of spouses is in issue, and if a spouse is residing in an institution but does not have an intention to be separate from his spouse, he's not considered to be separated for the purposes of the Divorce Act.

While we've used the word "living" here and might have chosen the more technical legal term of "residing," I think our intention is to deal with the issue on the basis of a mutually agreed-upon decision to be living separate and apart, rather than a physical separation in those terms. I don't know if that answers your question, but that was our intention.

**Mr Kwinter:** My problem is that I see different people taking different interpretations if that recommendation were to be adopted. I see it setting up problems and I just want to get your reaction to it.

**Mr Baker:** We could add the word "intending to be living apart" or something like that, or "wishing to be living apart." There may be other words that could be selected. I'm suggesting the Divorce Act might serve as the precedent because there it's the intention of the people which governs, not the physical arrangements. A person may be working in a distant country and in that sense be separated from the spouse, but the intention is that they are living together in the sense of husband and wife, and that's what we're getting at here.

**Mrs Sullivan:** I just want to say on behalf of the committee that we appreciate the extensive work that you've put into dealing with the redrafted bills. Your comments are thoughtful and we wish we'd had them before, I suppose, because we could have asked more questions about them.

There are a couple of comments I want to make, one of them with respect to Bill 108, section 75, criteria that you propose that incapacity be determined "beyond a reasonable doubt." The two issues I want to raise in that context are, first of all, the criterion associated with the assessors, about which we have no information because there's nothing written down in any of the bills about who will be making those assessments and, second, the criterion that you could establish beyond a reasonable doubt of incapacity.

Where would you find either one of those things and how can you be so definite in legislation, given that the decision would have to be made not only by the assessors but also by the advocates, for instance, under Bill 74 in terms of determining whether a person was not only incapable but vulnerable?

**Mr Baker:** Your first comment was a very generous one relating to the effort we put in. I'd like to say, just for the record, that we're aware of the effort that you personally have put in. I recall, when the amendments to this package came out, you had stayed up till 4 o'clock the night before and, over that evening, read them all and proved to us that you had read them all. So we're not the only ones who've done our homework.

Turning to the issue of proof beyond a reasonable doubt, the current standard in the Mental Incompetency Act is proof beyond a reasonable doubt on the application. When the court is reviewing the medical evidence which is submitted in affidavit form, the court must be satisfied beyond a reasonable doubt that the person is incapable; 99% of the cases go on the basis of that standard.

This represents a dilution from that standard. That's been the standard which has been in operation in this province for probably 100 years, and from our standpoint



there's no justification for moving away from that. If there is a doubt, then there are other, less intrusive mechanisms for intervening, whether it's an advocate, the Mental Health Act or a number of other mechanisms which are available to us.

What Bill 108 does is it says you no longer have a single legal right as an individual in Ontario. That's the impact of 108. There is no other statute which in any way approaches it in terms of intrusiveness into a person's humanity, as Ann West from People First said. In legal terms, it takes away every single right you have when you're found to be incapable under Bill 108.

What we're saying is if you're not 100% sure about that, we don't want judges making decisions, we don't want people being yanked before courts and we don't want People First members being intruded upon in any way with this legislation. They should not be.

The government assures us that's not its intention. The way to make that clear is to set a standard which is beyond a reasonable doubt. In our opinion, that is not asking too much of professionals. They are to provide their professional opinion. It's the court which must decide beyond a reasonable doubt. The professional merely offers his or her professional opinion as to the capacity of the individual, and the court, as has been done for 100 years in this province, has to weigh that evidence.

**Mrs Sullivan:** When the assessor takes that information with respect to his or her recommendation of incapacity, one would expect that there would be criteria for the assessors. Do you not see a weakness in Bill 108 in the fact that there are no criteria specified? There is no training, there is no proficiency or accountability required in legislation for the assessors.

**Mr Baker:** We have the Weisstub report. I must say I have my own reservations about the Weisstub report. In my view, it formalizes the whole process of finding incapacity beyond what is practical in most communities, certainly throughout the north, and I think it's unnecessarily formal, frankly.

None the less, that is available to the government, and in terms of designing mechanisms for doing assessments, that information is available. If courts decide that is the standard of evidence they're going to require, then that's fine. But to my mind that's a separate issue from this issue of the standard we're asking the court to assess the evidence against. Those are two separate issues.

Certainly a court is going to feel more comfortable with the comprehensive assessment process, multidisciplinary teams and the involvement of highly specially trained people in the area of doing assessments. That's wonderful. I think it's theoretical, frankly, in the north, where those people are not available to us, and I think that's why there was some hesitation in building it into the legislation.

The issue was addressed during the Fram task force process, with which I was involved from 1983 or 1984 until 1987 or 1988 when we wrapped up. We discussed these issues at great length and the decision was that because it was not practical in the north and we shouldn't build it into the legislation, at least at this point in time. I

must say I was persuaded that it couldn't be made to work in the north; the people just aren't there.

**Mrs Sullivan:** It's fairly shocking though, isn't it, that one region of the province is basically left out because it's an underserved area and therefore criteria aren't defined for the entire province, including the north?

**Mr Baker:** Absolutely. We're currently looking at a legal issue, whether it's discriminatory against people with AIDS because they cannot be treated in their home communities and are in effect forced into the city of Toronto because they cannot get physicians to meet their care requirements. Certainly that's a major issue for the province, but it's much larger, I think, than just the issue of assessment of capacity.

**Mrs Sullivan:** Mr Chairman, as this is the last presenter of the day, could I beg the indulgence of the committee to ask one more question with respect to Bill 109?

**The Chair:** If it's brief because, in fairness to all the other presenters, these people have gone over.

**Mrs Sullivan:** Right, I understand that, but it is a coalition.

**Mr Jim Wilson:** You're on a roll, Barbara.

**Mrs Sullivan:** I'm on a roll.

I want to ask, with respect to Bill 109, about an issue with which I have some concern. In fact you have raised it as something that you favour. That is that the consent to treatment, you suggest, should be defined as requiring consent for controlled acts, that treatment should be defined as controlled acts, but also that the consent should be required only for controlled acts that occur or take place in a facility or in an institutional setting. I am very concerned about that. It seems to me the consent should be for the treatment and not the place where the treatment takes place. I think you're dead wrong.

**Mr Giuffrida:** Perhaps I failed to make clear how we would see the scheme working. The definition of "treatment" would be equated to controlled acts plus behaviour modification. That being the case, treatment in any setting would require informed voluntary consent. The act would apply to it.

What I'm talking about is confining the situations in which there's a mandatory rights adviser visit. That's the kind of due process protection I was talking about that we think could appropriately be limited to circumstances where the patient is 12 or over and it is a controlled act or behaviour modification that is happening.

1620

**Mrs Sullivan:** Why would you want that difference in the rights adviser's involvement if it was the same procedure, the same consent and the same determination of incapacity, and instead of it taking place in a hospital, the decision being made or the treatment recommendation being made, it takes place in a doctor's office, all the other circumstances being the same? Why would you say there should be a rights adviser in a hospital but not in a physician's office?

**Mr Giuffrida:** Let me say first of all that in any setting the person should be told of the health care provider's determination of incompetence. If they're 12 or over and



it's a controlled act, they should be told about their right to have a rights adviser; they should be told that much.

What we are saying, as far as automatic rights advice goes, is that where the health care provider contacts the rights adviser and there's a visit, we would limit that to situations where it's in any hospital and a controlled act or behaviour modification. Your question is, why distinguish based on the setting? Any place you make a delineation like that will not be perfect. There'll be ones close to the line that you might wish were on the other side of the line, but generally speaking, institutional settings are ones where the patient has a greater risk of loss of autonomy and there's a greater risk that the consent won't be voluntary.

**Mr Jim Wilson:** I too want to thank you for your brief today. I find the tone of it to be very helpful and the approach to be somewhat more moderate than the last time we met.

**Mr Owens:** Mr Moderation himself.

**Mr Jim Wilson:** Hey, listen, I'm trying to be nice. There's really no need to ask me how long I stayed up to read the 199 amendments.

It's important, as we approach clause-by-clause, Mr Chairman, and perhaps this is best directed through you to Mr Fram, that on page 11 the group does make the point to ask the question why the clause, "The guardian shall take the person's current wishes into consideration, if they can be ascertained," was deleted.

Second, following on what Mrs Sullivan said in terms that the proof of incapacity should be beyond a reasonable doubt, I wonder if you can enlighten us what the discussion among ministries was pertaining to that.

I was also going to ask a question about treatment and controlled acts but I'll defer that one, so perhaps just those two to let us know, because certainly we were thinking along lines similar to this group.

**Mr Steve Fram:** On the first one, really, the one on page 11, listening to current wishes, we just moved it. If you look at page 36, we moved it down to subsection (3.1) from subsection (6). We reorganized it but the provision is still there:

"(3.1) In deciding what the person's best interests are, the guardian shall take into consideration...(b) the person's current wishes, if they can be ascertained."

So we didn't leave that out. I'm glad you asked that.

The other question, on the standard of proof, is a very difficult issue. I know David has been a strong believer in "proof beyond a reasonable doubt." The dilemma is that in various settings, as Mrs Sullivan pointed out, you're going to have assessors deciding on the balance of probabilities, you're going to have physicians deciding on the balance of probabilities, and you come down to the judge and you're going to say it has to be beyond a reasonable doubt.

When you start playing with the various elements of that, of when this applies and when that applies, and when someone believes that the physician has made the wrong determination and goes to court, for example, for a guardianship order or for a review board order, you get into all sorts of knots in terms of changing standards and inconsistent results.

On the other hand, the point philosophically that Mr Baker made is one that we all feel very strongly attached to. As he pointed out, it was one of the recommendations of the committee report which I chaired.

**Mr Jim Wilson:** I'm not a lawyer but I'm familiar with the standard, having worked with the courts in my career. Does anybody have any comment on what sort of equivalent safeguard could be put in there in particular, as this group has pointed out, to try to meet that very real concern that's been presented by People First?

**Mr Fram:** No one has come up with a better suggestion than the criminal standard of proof.

**Mrs Sullivan:** Which is?

**Mr Fram:** Which creates some real problems in seeing it as a system-wide standard.

**Mr Owens:** My question is both to Mr Baker and then to the Ministry of Citizenship with respect to the comments on page 2 of the brief, the issue of individuals with neurological disabilities and the exemptions of organizations from participation in the commission. I'd like Mr Baker to perhaps expand a little bit on that, and then ask the ministry why that was done, as there are different types of neurological disabilities and people function at different levels, and some of these individuals function at extremely high levels.

**Mr Baker:** Thank you very much for asking the question. As you may be aware, it's certainly an issue which is not only strongly held by the Ontario Advocacy Coalition but it's very strongly held by the Advocacy Resource Centre for the Handicapped, so thank you for giving me the opportunity to address the issue.

For us the issue is a very fundamental one. When I spoke to the minister about this issue a week ago last Monday, she said it was a compromise. I think there have been many compromises in this bill which have been constructive compromises. It's my position that this is an unprincipled compromise. It is a compromise with a fundamental principle about why we have advocacy legislation, why we're trying to empower vulnerable people. It's the kind of compromise I would hope the government would reconsider because it's the kind of compromise I think creates a fundamental flaw in the legislation. My organization feels very strongly about this.

I think the effort that was made by the government to satisfy a small group of family organizations—notably the Ontario Friends of Schizophrenics—was misguided. They, as an organization, are an organization of supportive family members. No one denies that they have the best interests of their family members at heart. The resources of the Advocacy Commission will be such that there will be little done in the way of advocacy for their sons and daughters because of their involvement, and that is as it should be and that is what we would expect.

That organization well understands that it is going to see little benefit from this legislation. When they come before you attacking the advocacy bill, they are basically saying, "For our sons and daughters, we could spend this money better somewhere else." But what they are not

taking into account is all the people who do not have supportive families about whom this legislation is intended.

The idea that we can compromise to satisfy this group or a small group of other organizations is, to my mind, unprincipled because it is pandering to that kind of purely political overture which is being made, and I think it's wrong that the government gave in on that point because this is about empowerment of vulnerable people.

**Mr Malkowski:** I'd like to refer this to Mary Beth.

**Ms Valentine:** I cannot respond to the original drafting of the bill, certainly. One of the significant issues that has been a policy decision for the minister has been in trying to determine whether in fact there are groups, and to the best of the ability of the minister's office and the office of disabilities there has not been the ability to determine that there are self-help groups, consumer groups, at this point that would be able to represent themselves on the commission.

The policy issue for the minister, the philosophical issue, certainly is that the minister would like to see people represent themselves the same in that category as in other areas. But the decision to date has been based on the factual information that there have not been those groups identified and that rather than have no representation of people who are in tune with, know, understand those issues, that has been the policy decision to date.

This issue has been identified, certainly by Mr Baker, very recently with the minister and I anticipate it will be an issue that the minister will want to at least revisit, review, at the end of the committee hearings after hearing submissions from all groups that come forward.

**Ms Fussel:** We all know that once a bill is enacted, though, it's hard to change. If this is left in as it is, what incentive will there ever be for the organizations to form? It's going to be more difficult for them to form. There is a real need for them to have a bit of support from government to try to come together now.

**Ms Valentine:** Again, Joan, I think your concern is very valid, and a very concern that the minister has addressed. At this point, her policy decision has been that should there be the need to bring forth amendments in three years, five years or whatever, as self-help groups begin to form and there's time for new elections and so on, that the ministry would be quite prepared to do so at that time.

**The Chair:** Ms Fussel, Mr Baker, Mr Giuffrida, on behalf of this committee I would like to thank you for taking the time out today in coming and giving us your presentation.

**Ms Fussel:** Thank you very much.

**The Chair:** Seeing no further business before this committee, we stand adjourned until 10 am Monday morning.

The committee adjourned at 1633.



## CONTENTS

Thursday 6 August 1992

<b>Advocacy Act, 1992, and companion legislation</b> . . . . .	J-101
Learning Disabilities Association of Ontario . . . . .	J-102
Eva Nichols, executive director	
People First of Ontario . . . . .	J-108
Judith McGill, adviser	
Anne West, vice-president	
Patrick Worth, past president	
Ontario Advocacy Coalition . . . . .	J-112
David Baker, executive director, Advocacy Resource Centre for the Handicapped	
Joan Fussel, co-chair; representing Concerned Friends of Ontario Citizens in Care Facilities	
David Giuffrida, acting provincial coordinator, psychiatric patient advocate office, Ministry of Health	
<b>Subcommittee report</b> . . . . .	J-108

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

- \***Chair / Président:** Cooper, Mike (Kitchener-Wilmot ND)
- \***Vice-Chair / Vice-Président:** Morrow, Mark (Wentworth East/-Est ND)
- \* Akande, Zanana L. (St Andrew-St Patrick ND)
- \* Carter, Jenny (Peterborough ND)
- Chiarelli, Robert (Ottawa West/-Ouest L)
- \* Curling, Alvin (Scarborough North/-Nord L)
- Harnick, Charles (Willowdale PC)
- Mahoney, Steven W. (Mississauga West/-Ouest L)
- \* Malkowski, Gary (York East/-Est ND)
- Runciman, Robert W. (Leeds-Grenville PC)
- \* Wessinger, Paul (Simcoe Centre ND)
- Winninger, David (London South/-Sud ND)

### **Substitutions / Membres remplaçants:**

- \* Kwinter, Monte (Wilson Heights L) for Mr Mahoney
- \* Owens, Stephen (Scarborough Centre ND) for Mr Winninger
- \* Sterling, Norman W. (Carleton PC) for Mr Harnick
- \* Sullivan, Barbara (Halton Centre L) for Mr Chiarelli
- \* Wilson, Jim (Simcoe West/-Ouest PC) for Mr Runciman

\*In attendance / présents

### **Also taking part / Autres participants et participantes:**

Fram, Steve, counsel, policy development division, Ministry of the Attorney General  
Malkowski, Gary, parliamentary assistant to the Minister of Citizenship  
Valentine, Mary Beth, senior policy and program adviser, Office of Disability Issues, Ministry of Citizenship

**Clerk / Greffière:** Freedman, Lisa

**Staff / Personnel:** Swift, Susan, research officer, Legislative Research Service



## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Monday 10 August 1992

### Standing committee on administration of justice

Advocacy Act, 1992,  
and companion legislation

Subcommittee report

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Lundi 10 août 1992

### Comité permanent de l'administration de la justice

Loi de 1992 sur l'intervention  
et les projets de loi  
qui l'accompagnent

Rapport de sous-comité

Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
Greffière : Lisa Freedman





### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

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### **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

### **Renseignements sur l'index**

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Monday 10 August 1992

The committee met at 1013 in committee room 1.

### ADVOCACY ACT, 1992, AND COMPANION LEGISLATION LOI DE 1992 SUR L'INTERVENTION ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervenants en faveur des personnes vulnérables; Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne; Bill 109, An Act respecting Consent to Treatment / Loi concernant le consentement au traitement; and Bill 110, An Act to amend certain Statutes of Ontario consequent upon the enactment of the Consent to Treatment Act, 1992 and the Substitute Decisions Act, 1992 / Loi modifiant certaines lois de l'Ontario par suite de l'adoption de la Loi de 1992 sur le consentement au traitement et de la Loi de 1992 sur la prise de décisions au nom d'autrui.

### ALZHEIMER ASSOCIATION OF ONTARIO

**The Chair (Mr Mike Cooper):** Good morning. Just a reminder that you're allowed a half-hour for your presentation. The committee would appreciate it if you would keep your comments to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, please identify yourself for the record and then proceed.

**Mr John Ellis:** It's a pleasure for us to be here again to present to you. I'd like to begin by introducing Angela Morris, the past president of the Alzheimer association and the chair of the public policy committee, and Susan Kitchener, our public policy manager. My name is John Ellis. I am the executive director and I will be doing the bulk of the presentation here this morning.

You have copies of our written brief before you and I will be going through that with you, but just hitting the highlights. In the interests of time, we will only be able to cover verbally the main points in there. Of course, if any of the members present wish to meet with us afterwards, we will be more than happy to do so. We are also making the brief available in disc form for visually impaired persons upon request.

First, let me begin by giving you a little background. Current estimates put the number of people in Ontario with Alzheimer disease at 120,000, with projected increases of 50% over the next decade. Projections indicate that by the year 2000, fully half of all residents in long-term care facilities will be people with Alzheimer disease. Sheer

numbers alone dictate that a major focus of the advocacy system will be people with Alzheimer's.

Alzheimer's is a condition marked by a continued, cognitive deterioration, beginning with simple forgetfulness and ending with the inability to eat, to recognize loved ones and to control one's bodily functions. The diagnosis of Alzheimer disease means the beginning of a life of progressively increased care, usually by a spouse, followed most often by institutionalization and inevitably by death. It means a life where, for the next two to 15 years, a person with Alzheimer disease must depend on a care giver who can expect a partner to change personality, to wander from home without warning and to lose all decision-making ability.

The Alzheimer Association of Ontario reiterates its support for the intent of the proposed legislation, in particular for its effort to protect the rights of vulnerable people. We reiterate our offer to the Minister of Citizenship to work with the ministry and the Advocacy Commission, once it is set up, to develop practical tools that will help to ensure that the advocacy system works to the advantage of people with Alzheimer disease.

In its previous submission to the standing committee on administration of justice, as well as in verbal representations to the Minister of Citizenship and to senior civil servants, the Alzheimer Association of Ontario has indicated not only its support for the principles behind the proposed acts, but also has expressed very serious concerns about the impact of the acts on some of the most vulnerable people of all, those with Alzheimer disease.

In particular, we took issue with the thrust of the bills in ignoring supportive families and care givers as key allies in helping to ensure that the considerations of vulnerable people themselves determine decisions about their lives.

I'd like to give you a general overview of our reaction to the amendments. First of all, I would like to commend the government in trying to reflect in its amendments the concerns we've expressed that much too formal a system had been developed to resolve problems where no conflict exists. The Alzheimer Association of Ontario appreciates the government's attempts to remove some of the barriers which we believed had the potential to put at risk vulnerable people, especially those in the mid to late stages of Alzheimer disease.

We continue, however, to have reservations about the system as proposed. We question whether sufficient financial, planning and implementation resources are in place to enable such a ground-breaking and complex system to deliver its laudable goals. To that end, we make the following general recommendations:

First, that the government table implementation plans, including time lines for all components; second, that the government table projected total annual costs as well as



total startup costs; third, that the acts themselves and components of the acts be phased in, in order to (1) develop assessment standards and procedures, (2) develop training programs for advocates, assessors and rights advisers, (3) develop codes of conduct and a complaints process, and (4) develop procedures, criteria and standards.

1020

Turning now to the Advocacy Act, Bill 74, in particular, the intent of the act is to ensure that vulnerable people themselves are enabled to make decisions about their own lives. Decisions under which the Advocacy Act, Substitute Decisions Act and Consent to Treatment Act become operational will be taken from the perspective of vulnerable persons through the Advocacy Commission, a majority of whose members must be or have been vulnerable adults. This latter provision will guarantee, for most groups, that over some period of time a thorough comprehension of the unique consequences of their vulnerability will ensure informed decision-making by the commission. I'm not sure how much longer this is going to last: the voice, that is.

However, for the approximately 120,000 people in Ontario who have Alzheimer disease, this will not be the case. Tragically for them, the rapid deterioration caused by the disease presently precludes representatives in the mid to late stages of the disease from bringing to the commission insight into the experience of living with it. Without such representation, how will the Advocacy Commission comprehend the effects of this increasingly prevalent disease, and in particular the incapacitating effects of its mid to late stages?

We recommend therefore that, because it's critical the commission have the capacity to make decisions that fully take into account the severe functional limitations of Ontarians who are arguably the most vulnerable of all, people with degenerative neurological diseases, the Advocacy Act be amended to provide the commission with a formally mandated advisory committee.

Because there is no provision for representation of people with the experience of mid to late stage Alzheimer disease on the Advocacy Commission, we view as essential the inclusion of family members of people with Alzheimer's on the advisory committee to the commission.

Let's talk about accountability a little. There appears to be a gap in accountability and responsibility between the commission, on the one hand, and the cabinet and the Legislature, on the other hand. This leaves an unsatisfied complainant with only the courts as recourse. When the purpose of the whole system is the empowerment of vulnerable people, surely it is not the intent to force them into litigation should they disagree with a decision of the commission.

The Advocacy Act requires that the commission "establish, subject to the approval of the Minister of Citizenship, and make available to any person on request, a written review procedure for dealing with complaints from any person relating to advocates."

Clearly, the first step in laying a complaint about an advocate will be through a complaints and review procedure of the employer, the Advocacy Commission. However, there must be, beyond this, an independent appeals

body before which appellants may make their cases. We urge establishment of an independent review body similar to such tribunals as the Social Assistance Review Board and the Health Services Appeal Board.

Moving on to this newly created rights adviser, the amendments to the Consent to Treatment Act introduce these rights advisers without clearly identifying their role, accountability, criteria or training. The responsibilities outlined in the legislation do not give them the full authority of an advocate, but rather that of an informed facilitator providing rights advice to the patient when required, facilitating consent to treatment and assisting patients with appeals to the Consent and Capacity Review Board. Unlike advocates, they would not do systemic advocacy.

The process under which rights advisers work must preserve the intent of the legislation in ensuring that vulnerable people have advice that gives their rights primacy, both in fact and in perception. We therefore believe that rights advisers must be both accountable to, and authorized by the Advocacy Commission. The commission must be responsible for the qualifications, standards, procedures, a complaints process, recruitment, training, reimbursement as well as management of the rights adviser program.

As we've indicated in earlier submissions, the Alzheimer association believes that the biggest challenge in making the advocacy system work to the benefit of people with the disease will be ensuring that advocates, assessors and members of the commission itself are thoroughly knowledgeable about the effects of the disease. Appropriate training will be critical.

While we understand the intent of training advocates from a consumer perspective, we would argue that the complexity and constant change in the functional limitations caused by Alzheimer disease, as well as procedures for dealing with those limitations, require quite specialized training.

We recommend therefore that the act be amended to require formal training programs for advocates, such programs to be developed with input from consumer groups, such family support groups as the Alzheimer Association of Ontario and expert advisers.

The amendments address the issue of non-instructed advocacy, and we applaud the government for clarifying in these amendments to the Advocacy Act when and how an advocate may provide advocacy services to a vulnerable person who is incapable of giving instruction. We commend in particular the provisions allowing for the advocate to take instructions from substitute decision-makers and to help family and friends in assisting the person who is incapable. In these provisions is a welcome recognition that supportive family and friends are key allies not only for incapable vulnerable persons but also for advocates.

The difficulty for the Alzheimer Association of Ontario in this area lies in how the advocate will determine (a) whether a vulnerable person is incapable of giving instruction and (b) whether there is a risk of serious harm to the health or safety of that person.

We recommend three things: first, that the commission must seek the written advice of the advisory committee to the commission in defining the procedures through which



advocates determine the capability of vulnerable persons to give instruction and that such procedures be included in regulation; second, that the commission define in regulations "reasonable grounds to believe there is a risk of serious harm to the health or safety of the vulnerable person"; and third, that the regulations setting out the procedures to determine incapability of giving instruction and determination of risk to health and safety apply to subsequent sections of the act and in particular to those sections dealing with the advocates' right of entry, access to records and confidentiality.

Let's move forward to the Substitute Decisions Act. The Alzheimer Association of Ontario again commends the government on accenting the real need that exists where vulnerable people are alone or in dysfunctional relationships but assuming that the preponderance of families are actually caring and supportive. Our overriding concerns with the act are whether the office of the public guardian and trustee will have resources sufficient to meet the many key responsibilities required by the three bills and the degree to which officials within the office of the public guardian and trustee are knowledgeable about functional limitations of the progressive stages of Alzheimer disease and are sensitive to the problems this causes.

We recommend that in order to ensure effective functioning over the long term of the office of the public guardian and trustee and to facilitate supportive relationships with families and other allies of incapable vulnerable persons, a permanent liaison group be set up within the office of the PGT to work on an ongoing basis with such organizations as the Alzheimer Association of Ontario.

We appreciate the provisions of 46(a) to (c) which enable supportive family members, through an unvalidated power of attorney, to provide and/or decide on personal care and/or treatment for a vulnerable person as long as that person does not object. Both the provisions for unvalidated power of attorney and for expedited validation are good, sensible public policy. However, making that policy function well is dependent on the accuracy of the criteria and procedures in determining capacity and on the standards and knowledge of the assessors in putting those criteria and procedures into practice. It is on the latter point that we have our greatest reservations, particularly where such determination would apply to people with Alzheimer disease.

We are recommending that the Substitute Decisions Act be phased in only when, and not be promulgated until, a training program for assessors in the determination of capacity has been developed, in consultation with expert advisers, including such organizations as the Alzheimer Association of Ontario, and the number of assessors sufficient to carry out the requirements of the three acts have undergone the training program specified above.

1030

Regarding validation of the power of attorney for personal care, as we've indicated, we commend the government for the provisions for personal care under unvalidated power of attorney and expedited validation of power of attorney. However, families of people with Alzheimer disease will in most cases find themselves having to go through the most onerous of the power of

attorney procedures: validation by the public guardian and trustee. In addition to being complex, lengthy and demanding, the requirements may also prove costly.

Consider the daunting tasks that face, for example, a 70-year-old woman who currently cares for and wishes to go on caring for her husband who has Alzheimer disease. First, she must have the assessments done by two qualified assessors to determine that her husband is indeed incapable. Next, she must file an application to have the power of attorney validated by the public guardian and trustee. She then has to prepare a guardianship plan which will accompany the application. Together with the above, she must file a form proving a qualified assessment has been done by two assessors. Then an advocate must meet alone with her husband to explain to the man with Alzheimer disease that he is the subject of an application and that he has the right to oppose it.

The woman may not be sure what training the advocate has but she will certainly hope that the advocate has a thorough knowledge of the effects of Alzheimer disease; that, for example, her husband may just continue to say yes to all questions and that he may appear to be quite capable when in fact he isn't. Next, the advocate prepares a written report for the public guardian and trustee on the results of the meeting. If there's any dispute, the courts must be involved.

This is quite a process to go through in order to go on caring for an incapable loved one and to go on making the decisions you are aware he would choose, were he capable.

We're recommending that in cases in which Alzheimer disease is determined by two assessors to be the basis for their finding of incapacity, and where the application for validation of power of attorney meets all the criteria required by the PGT, excepting that the person alleged to be incapable instructed the advocate to challenge the application, the public guardian and trustee shall validate the power of attorney.

One of the disturbing results of the Alzheimer disease process is a propensity for the Alzheimer patient to wander off without a second's notice. This poses real problems for family care givers who must ensure that the person with Alzheimer disease has someone present at all times. This is one of the reasons that long-term care facilities are often reluctant to accept placement of people with Alzheimer disease.

Subsection 65(2) of the Substitute Decisions Act stipulates that a guardian of the person cannot change an incapable person's place of residence to a more restrictive setting unless the PGT or the court, on the guardian's application, authorizes the change. If this is interpreted to include movement of, for example, a person with Alzheimer disease from one ward of a nursing home to a special Alzheimer ward which may be locked, we can foresee much exacerbation of the current difficulties in placing people with Alzheimer disease in appropriate long-term care facilities.

We're recommending that the act be amended to indicate that where Alzheimer disease is present, approved treatment plans may include provision for possible movement to a more restrictive setting, and that where approved



treatment plans contain a provision for possible movement to a more restricted setting, further authorization from the PGT or the court is not required, provided that the guardian consents to the move.

Time is rushing on here so rather than go through the responses on the Consent to Treatment Act, you will see in our brief a number of important considerations there, not the least of which is the last recommendation, trying to define what the wishes of an incapable person are.

Let me only say, related to this act, that as an organization whose members have, as one of their first principles, a commitment to determining the causes of, and ultimately a treatment for, Alzheimer disease, we are particularly pleased that the government understood and in the amendments to Bill 109 heeded our pleas regarding Alzheimer research.

With that I will stop and open the floor.

**Mrs Barbara Sullivan (Halton Centre):** I want to thank the association for a comprehensive and I think very useful brief to the committee. Because you didn't have an opportunity to walk through the Bill 109 portions of the brief, I think that's where I'll concentrate my probably one question.

Looking at your recommendations with respect to the finding of incapacity and at your recommendations that section 10 be rewritten, my reading is that the act now requires rights advice that differs in different places when a determination of incapacity has been made. Your recommendations, it seems to me, based on the nature of the treatment and whether a person is capable with respect to that particular treatment, not based on the location, are a more appropriate route.

One of the things that strikes me, as I look at this and at your other recommendation that rights advisers be employees of the commission, is that perhaps in its rewriting of 109, it appears that the government's intent is not to have rights advisers paid by the commission and accountable to the commission, but in fact to have them accountable and paid by probably the institution in which the advice is being given, which is why there's a separation of the location. That seems to me what's happened.

Could you comment on that, and indicate why you have gone this way?

**Mr Ellis:** In regard to those who are delivering let's call it general advocacy services, including those that the rights advisers are designated to provide, which are of course not clearly spelled out here, it's very important that there be consistent control over their activities. Someone has to be watching them carefully to make sure the kind of advocacy that's envisaged by the legislation is being provided.

Even though, as I say, it isn't spelled out clearly what the differences between advocates and rights advisers are, even though there appears to be some indication, it seems to be logical to have the same body overseeing both groups since they are both part of the same system and providing essentially two different parts of the same service. This is why we've gone with having them accountable to the Advocacy Commission.

**Mrs Sullivan:** And the controlled acts are the parameter for the determination of rights advice. I think that's very useful. I like this recommendation.

**Mr Norman W. Sterling (Carleton):** I'd like to add my comments to Mrs Sullivan's in terms of the depth and the thought behind your brief. You've obviously done a lot of work, and I thank you for that.

I guess the bottom line in all this is, are these pieces of legislation going to be advantageous in total over the present situation or not? I get the impression that if they accepted a major number of your recommendations you may be a little bit ahead, but taking the assumption that few of your recommendations would be accepted, which is the normal procedure in legislation, are you going to be further ahead or further behind after this legislation comes forward?

**Mr Ellis:** Assuming "few" or "a few"?

**Mr Sterling:** I'd say very few. Maybe I'm prejudging the government on it, but in most cases that happens in terms of legislation. They're reluctant, at this stage, to add many more amendments.

1040

**Mr Ellis:** Well, I would like to think the government is listening.

**Mr Sterling:** I hope so too, but—

**Mr Ellis:** I hope so. I'm optimistic because there were certainly some positive responses to our first brief. The last point I raised was regarding the change on research. I think there are indications that the government has listened to our recommendations for improving the legislation up to this point. I can only base my assumption on that prerequisite; that they will continue to listen, and that there will be further changes as we have outlined here.

**Mr Sterling:** If there are not?

**Mr Ellis:** If there are not, there will remain some very important flaws in this legislation. For instance, we don't even know whether the government can afford to implement it. We haven't seen any budgets or anything like that.

**Mr Jim Wilson (Simcoe West):** They don't want to talk about it.

**Mr Ellis:** Well, one of our recommendations is that we get the—

**Mr Joseph Cordiano (Lawrence):** The government can't afford anything these days.

**Mr Ellis:** I think it's fair, before implementing any program, to ask how much it's going to cost. Until we've got some idea, I don't see that this legislation should really go forward.

I think we are afraid too that if the strength is not given to this advisory committee—the Advocacy Commission is going to have a great deal of power, and if it doesn't understand something like Alzheimer's disease or doesn't have, in a sense, required information, required support and understanding for this kind of disease, then it will be acting without the best knowledge, and decisions will be accordingly poor. We realize that on the Advocacy Commission they want to have persons who are or have been vulnerable,



but they certainly need good advice from groups like our own. That's where the advisory committee comes in. The advisory committee needs some strength. It's been improved in this recent go-round in that the minister must set up the advisory committee, but there's no assurance that it will have any teeth. Unless that's mandated and they have to file annual reports and this sort of thing, we are afraid it can't work very well.

**Mr Gary Malkowski (York East):** Thank you, Mr Ellis, for your presentation. It was very comprehensive and beneficial.

You said to strengthen the Advocacy Commission in terms of the Alzheimer perspective. At the moment, your group has applied to have a person on the appointments advisory committee, under paragraph 15(1)2. Do you suggest that to make the advisory committee mandatory or stronger will be better? There has been a suggestion by some other groups to have the exception removed, which will allow giving the nominations to the appointments advisory committee. What do you think about that?

Second, the Alzheimer's people who are early-diagnosed Alzheimer's have some knowledge and may be better able to develop a self-help group. Those people could then make decisions in terms of coming from a consumer's perspective. There is one member of Parliament in New Brunswick who has been diagnosed with Alzheimer's and he still functions in the Legislature, so I'm just wondering what you think about an Alzheimer's group of early-diagnosed people and coming from their perspective.

**Mr Ellis:** Thank you very much for that question. It gives me the opportunity to clarify that if there is a strong, mandated advisory committee, that is, an advisory committee to the commission, there will be no need to have a person with the disease on the commission itself. This is our point.

Regarding the appointments advisory committee, this is a different committee, of course, which simply appoints people to the commission. Originally we had taken issue with the fact—"originally" meaning a couple of months ago—that it didn't appear as if the voice of Alzheimer's was going to be heard on the commission.

At that point we were not looking at a required advisory committee. Now we're looking at a required advisory committee; this is not the appointments advisory committee but the advisory committee to the commission. With that committee strengthened, our role will be much more valuable there than trying to find someone who is going through the stages of Alzheimer's disease that will require they eventually terminate their membership on the committee.

You understand also that when a diagnosis of Alzheimer's disease is made, there is tremendous trauma for the individual and the family. Mr Malkowski, you're referring to the federal member of Parliament who has recently come forward publicly to say he has Alzheimer's disease. This man is now getting his life together. He's resigning from his position as an MP and going through what are very difficult and traumatic circumstances for his family.

We do not recommend, given the uncertain nature of the speed with which a person deteriorates and the traumatic family situations people with the diagnosis find themselves in, that they be appointed to the commission themselves.

**The Chair:** Thank you, Mr Malkowski. Mr Ellis, Mrs Morris and Mrs Kitchener, on behalf of this committee I would like to thank you for taking the time out this morning and giving us your presentation. Thank you.

**Mr Ellis:** My pleasure.

1050

PETER A. SINGER

**The Chair:** I'd like to call forward our next presenter, Dr Peter Singer. Good morning. I remind you that you will be allowed a half-hour for your presentation. The committee would appreciate it if you would keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, please identify yourself for the record and then proceed.

**Dr Peter Singer:** My name is Peter Singer. I'm the associate director for the Centre for Bioethics at the University of Toronto and assistant professor of medicine there. I obtained my medical degree from the University of Toronto in 1984 and my master of public health degree from Yale University in 1990. I'm a fellow of the Royal College of Physicians and Surgeons of Canada and the American College of Physicians. I practise internal medicine at the Toronto Hospital and my principal research focus is in bioethics, particularly in living wills and advanced directives.

I wish to acknowledge the assistance of Sujit Choudhry in preparing this presentation. As well, I wish to acknowledge my research support. The Centre for Bioethics is supported by a health systems-linked research unit grant from the Ontario Ministry of Health and I'm supported by a medical scholarship from the Canadian Life and Health Insurance Association and a teaching and research scholarship from the American College of Physicians. However, the views I'm about to state are my own and don't represent the position of the supporting groups, my faculty university department or centre.

I appreciate the opportunity to appear before the committee again to comment on the amendments to Bills 74, 108, 109 and 110. In this presentation I'll review the three principal recommendations related to rights advice or advocacy, emergency treatment and powers of attorney for personal care that I made when I appeared before this committee on February 10, 1992.

First, rights advice: In my previous presentation, I recommended that section 10 of Bill 109, related to rights advice, be restricted in scope and offered a justification for that in an article, appended to the presentation, that's subsequently been published. The proposed amendments are certainly a step in this direction. In addition, I recommend the following change to subsection 10(3). I think subsection 10(3) could be amended to read, "The health practitioner shall ensure that the person is advised of his or her right to



request a meeting with the rights adviser and to make an application to the board under section 26."

This is similar language to subsection 10(1), and the change really would make the legislation more sensitive to the cultural context of health care. Even the most important information in health care, such as diagnosis, prognosis and proposed treatment options, is transmitted verbally between health practitioners and patients. Moreover, the lesson of informed consent is that the nature of the dialogue between health practitioners and patients is much more important than the written form itself. Requiring written notice in this section, I think, would seem overly legalistic to most patients and health practitioners and divert attention from the importance of the dialogue itself.

Even with these changes, the legislation would establish a major rights advice program. It would be important to ensure that the program met its goals and the needs of health care consumers. Therefore, the program should be evaluated in an objective manner. Thus, I suggest an additional amendment to Bill 109, which could be somewhere following section 45: "The Minister of Health shall ensure that the provision of rights advice, as required under various sections of this act, will be evaluated by a qualified research group which is at arm's length from the Advocacy Commission." The Institute for Clinical Evaluative Sciences, recently established by the Ministry of Health and the Ontario Medical Association, would be extremely well qualified to conduct such a program evaluation.

The second area I'd like to turn to is that of emergency treatment. In my previous presentation, I recommended that the definition of an emergency in section 22 of Bill 109 be changed to include not only surgical but also medical emergencies. I provided the example of thrombolytic therapy for a heart attack and suggest that, though it's an emergency, it might not have fallen under the original section 22 definition of an emergency. With the amendments and the change in language of that section from "likely" to "at risk," I think this concern has been addressed.

The third area I'd like to focus on is powers of attorney for personal care. In my previous presentation, I stressed the need for public education regarding powers of attorney for personal care. This concern has not been addressed by the amendments. A recent research study conducted by myself and Mehran Sam, a graduate student at the Centre for Bioethics, showed that of 105 outpatients attending an internal medicine clinic 16% knew about living wills, 11% knew about durable powers of attorney for health care and 4% knew about advance directives. Their knowledge of these terms is extremely limited, and would be more limited regarding the term "powers of attorney for personal care," which is even newer than these other ones.

Moreover, although none of the patients in the study had completed an advance directive or living will, the majority wanted to complete one after we explained to them what an advance directive was. Without public education, I don't believe Ontarians will be able to take advantage of the power of attorney for personal care provisions in the legislation. Therefore, I proposed the following amendment to Bill 108, which could come after section 83: "The

public guardian and trustee will develop a public education program regarding powers of attorney for personal care."

In my previous presentation, I also stressed the need for a careful design of power of attorney for personal care, advance directive or living will forms. Section 47(8) of Bill 108 states, "The power of attorney may be in the prescribed form," and section 83 of Bill 108 states, "The Lieutenant Governor in Council may make regulations prescribing forms." Many different forms are available, and these should be carefully studied.

At the Centre for Bioethics, we have developed our own form, which is in compliance with the proposed legislation. This form has been developed based on my knowledge of clinical medicine, questionnaire design methods—because after all, these really are questionnaires—and other living will forms. It was reviewed by more than 25 physicians, nurses, lawyers and ethicists, and I might just take a moment to walk through the form, which is the attachment you have, page by page.

On the first page, on the overleaf, there are two sections. The first section, "What is a living will?" defines and describes living wills and the two types, instruction directive and proxy directive. We went with the term "living will" because, based on our survey data, this is the term most familiar to Ontarians. It says what a proxy directive and an instruction directive are.

I'll remind you that a power of attorney for personal care is at least a proxy directive—it names whom you want making decisions for you—and could be a combined proxy instruction directive; you may also be able to say what you want.

In the next section, "Who should complete a living will," it says that anyone over 16 should consider one, but to do it you have to consider your own death, which people don't like to do, which is why many people don't have testamentary wills. It says that if you're now healthy you may be more inclined to think about proxy directives because it's easier to figure out who you want making decisions for you than what sort of hypothetical decisions you want, but if you're sick you may want to do both because they're complementary.

Over the page we talk about how to make an instruction directive and a proxy directive. It really just talks about the sorts of situations and treatments, the sorts of proxies, you may want to consider.

The situations themselves are on the following two pages. I've listed here six health states which I think are pretty exhaustive of the health states people should be thinking about in a living will: dementia, permanent coma, temporary coma or delirium with ongoing thinking impairment, temporary coma or delirium with ongoing physical impairment, temporary coma or delirium with full recovery, temporary coma or delirium and a residual terminal illness. It's hard to think about other situations people might get into, and it describes these generic situations a little bit.

Then it goes on to talk about the principal treatments that are used in these situations, so it's really providing information to people so they can complete these forms based on some information.



The next page talks about what to do with your completed living will. One of the problems is portability: How will health providers or health practitioners know that a person has completed a living will? It basically says to send one to your proxy, your health practitioner and everyone else you can think of. I notice there are some new provisions regarding a registry in Bill 108 that may also be helpful in this regard.

"When should you update your living will?": When your health status changes and so on, and it provides some times when you might to do that.

The next section talks a bit about this legislation and the legal status of living wills in Ontario. It basically says that this living will has been written to conform with this proposed legislation, but there currently isn't any enacted legislation.

The remaining pages are the living will itself. The first page at the top the living will is identifying information and witness information. You'll see the little statement at the bottom that the witnesses have no reason to believe the person making this living will is incapable of making one, which is there to conform with this legislation.

The next page is the instruction directive with the health states listed across the top, the treatments that have been defined listed across the side, and in each case the person may choose, "Yes, I want this treatment in this health state," "No, I don't," or "I'm undecided." This is meant to go with the information I discussed before. This can be intimidating to some people, no question, but people have been able to complete other living wills of this format. As I say, the proxy directive alone without the instruction directive would also work.

The next page is a proxy directive and room for a personal statement, and then a little bit of information about the centre.

That's the living will we've developed, thinking ahead about this legislation. During the next year I expect to distribute it to patients and evaluate consumer satisfaction with the Centre for Bioethics living will.

Moreover, in connection with Manitoba's recently passed advance directive legislation, the Manitoba Law Reform Commission has asked if it can adapt this Centre for Bioethics living will for use in Manitoba. I've agreed to work with them in developing a living will for Manitoba based on the Centre for Bioethics living will, and I'd be happy to offer the same assistance to those developing power of attorney for personal care forms in Ontario.

Moreover, I recommend that if legislation is passed then the impact of living wills in Ontario should be evaluated. For instance: Are patients completing them satisfied with them; are families satisfied with the process at the time the living will springs into use; what is the impact of living wills on the utilization of health services, and so on. We're currently working on a more restricted evaluation, a similar evaluation, of a dialysis-specific living will in collaboration with the Institute for Clinical Evaluative Sciences.

In conclusion, the amendments to the proposed legislation have in part addressed the main concerns I outlined in my previous presentation before the committee. With re-

gard to rights advice, I've offered an additional change and emphasized the need for program evaluation. With regard to emergency treatment, I think the amendments have responded completely to my concerns. With regard to advance directives, I've emphasized the need for public education and offered my assistance in the development of living will forms for Ontarians.

I'd like to thank the committee for this opportunity to appear before you a second time to comment on these bills, and I would be glad to answer any questions you may have.

1100

**The Chair:** Thank you. Questions and comments? Mrs Sullivan.

**Mrs Sullivan:** Thank you, Dr Singer. This is an impressive piece of work and I think it's one that Mr Sterling will probably have a lot of comment on because he has worked particularly on the living will area, as you know.

My understanding is that there are standard forms for living wills available in places like Grand and Toy and other stationery stores and that the advice that is now being provided by the Ministry of Health and the Ministry of the Attorney General is that those forms not be used and that legal counsel be sought. Could this kind of living will, in your view, be completed with the advice perhaps of a physician without the intervention of counsel?

**Dr Singer:** Yes, in my view it can. I think that it could be.

I'd like to stress that there are many living wills available. People class them in generations. The first generation of living wills is flawed in that, for instance, sometimes they only apply to terminal illness, whereas the legislation doesn't. The second generation of living wills, an example of which is the medical directive created at Harvard by Linda and Ezekiel Emmanuel, is more comprehensive in the medical information they provide informing people. I think this is a second-generation one.

In studies by the Emmanuels about their living will, which is probably even a little more complicated than this one, they found that people could complete them in a median of 16 minutes in consultation with their health providers. In fact, I think that people could even begin to complete these at home. The way I envision a living will program is people could have this information, take it home, review it, think of it, possibly pencil in some choices talking to their families, their potential proxies, and then have it reviewed by the health provider, who is really serving as a resource person. It's particularly important for the instruction directive component, where we can only provide very general information for healthy people really, "Here are the possibilities you could get into," but providers could modify that information to really suit the individual situations of people.

I might also say that I think the third generation of living wills will be families of living wills developed for people with particular types of illnesses. For instance, we've developed a dialysis-specific living will in which you have to list pretty well the same situations, because you don't know what health states people are going to get



into, but it turns out you only have to list two treatments, namely dialysis and cardiopulmonary resuscitation, because all of the other treatments are trumped, if you will, by a decision to continue or stop the dialysis.

Similarly, if one's thinking about the HIV context, one may have the same spectrum of treatments but the situations are completely different. For instance, when we showed this living will to groups of persons with HIV, they rightfully pointed out, "What does full recovery with terminal illness mean in our context?" and many of the situations are ambiguous to persons.

So I think living wills need to be individualized to various groups and I think that will be the third generation of living wills, and we've begun to work on that.

That was a long answer to your question. The real answer is yes, I think this can be filled out by people alone, reviewed by health practitioners, and I think it would be up to people whether or not they'd need to review this with legal counsel.

**Mrs Sullivan:** If I have a chance for a second question, it's not on the living wills; it's on Bill 109. You've recommended that ICES or a similar body evaluate the provision of rights advice and the components of rights advice. How would you see that working?

**Dr Singer:** I think that rights advice, generally speaking, is a good idea. In a tailored way, as it's begun to be modified, it may be a helpful addition in the health care context.

The way I'd see it working would be like an external contract, like in the research grant model, I think. Just now, as things are contracted out to research bodies for external evaluation, I think such a program evaluation could easily be contracted out.

If I were the person performing that research—I wouldn't want to be, but if I put myself in his shoes—the first thing I'd do is I'd look at the articulated goals of the program and then develop instruments to evaluate the program against those goals. I think, for instance, one of the things you might measure is consumer satisfaction and reaction to the intervention of rights advisers: Do consumers who have actually gone through this regard it as a positive or negative thing? I should think that this information, objectively and fairly collected, would be a valuable addition in modifying the program to best meet the needs of Ontarians. That obviously wouldn't be the only evaluative question, but I think an important one to elicit, just as we're interested in knowing about consumer satisfaction with our living will document.

**Mr Sterling:** Thank you very much for coming in front of our committee again, Dr Singer, as I know you have put a lot of effort and time into the whole aspect of advance directives and living wills.

I think it should be clear to the committee, as I believe your brief is, that you're making no attempt to deal with Bill 74 to any extent but are restricting your comments to the advance directives and the living wills.

**Dr Singer:** Yes, I'm not attempting to deal with Bills 74 or 110. I have dealt with certain provisions of Bill 109—section 10 and section 22—and I've dealt with the

"Powers of Attorney for Personal Care" part of Bill 108. That's where I've focused my attention.

**Mr Sterling:** I'm interested in your showing us a form of a living will, because I think it's important for us to focus on the practicality of it.

Bill 108 was improved in terms of taking away the requirement for validation of all advance directives, or "proxies" as you put it, durable powers of attorney for personal care. Under section 83, the Lieutenant Governor in Council can put forward forms. You've indicated that these things are changing as people gain experience. Do you think it's wise for them to have a standard form?

**Dr Singer:** Yes, I do, because the real challenge with advance directives is public education, and one of the best ways to educate the public is to make such a resource available. If you say, "We don't recommend the Grand and Toy ones," then eventually you are going to have to recommend one. However, it's only wise if that's a good form. People like the Emmanuels in Boston have spent their whole lives designing good forms.

I think that if the form is good, it is wise, and I also think it's not an issue frozen in time. I think one needs to evaluate the form in an ongoing way. For instance, we've done studies, almost like marketing surveys, if you will, where we've handed out two advance directive forms in random order to 100 patients. We have an instrument to measure their satisfaction with these forms. We ask them which one they prefer and why, and from that sort of information we can develop better forms, so I think ongoing support and form development would be helpful.

In summary, I think it is helpful to recommend one, but only if the one that is recommended is a really good one and supported by good information.

**Mr Sterling:** Perhaps when they develop these forms the words across the top should be that this is not an exclusive form and that it does not negate the previous efforts to either give a durable power of attorney or make a living will.

**Dr Singer:** Yes, I think it would be a mistake to require a particular form. One of the things we found in our studies was that when we gave two people two very different forms, their overall satisfaction was the same as a group, but when we asked them which one they preferred, half preferred one and half preferred the other, which led me to the conclusion that different people like different forms and a variety should be available.

Therefore, I think it would be good to prescribe—let me use plain language—to offer a form for people to use if they want, but not to require that they use that form.

**Ms Zanana L. Akande (St Andrew-St Patrick):** In relation to Bill 109 on rights advice, you are recommending that the advice be given similarly to advice given in all other health care situations, orally rather than in written form. I'm wondering if in fact the seriousness of the situation, the permanence, the length of time this decision may extend over, because it could be a very long time, would not warrant something different, something more significant, something in writing.



1110

**Dr Singer:** Yes. It's interesting because if you come at this from a long-term care perspective, you reach exactly that result if you come at it from the framework of guardianship and so on. Looking at it from the long-term care perspective, I'd agree with you.

However, as I come at it from the acute care perspective—I practise internal medicine in a hospital, people come in through the emergency room, I see them for 7 or 10 days in hospital and then they get better, recover and go home—I come to the opposite perspective and say that in those situations, information about prognosis, what's going to happen to people and what you want to do to them, is at least as important as that other information. I think people would regard it as overly legalistic to be thrusting forms in front of them.

I think it's fair to say that one of the lessons of consent forms for surgery is that sometimes the process has under-cut emphasis on really the substance of the dialogue. I'm concerned that at least in the acute care situations this might be the same problem. It would be up to presumably the health practitioners to show that they had provided this advice, just as they have to show they got consent for various procedures. In that case, if I were doing it, in certain circumstances I may well use a written form because that's the best documentation I may have. But to require that in all circumstances I think might be viewed as overly legalistic.

I don't feel strongly about this. This is a change really intended just to fine-tune something that I think has already changed quite a bit in the right direction. But I did want to raise that possible modification.

**Ms Akande:** My concern, if I can continue it just one moment longer, was the possible legal implications with someone who is in this situation for a very long time and the implications for others if they should be challenged. If in fact at some later date this should be challenged in terms of the person's rights, it might in fact demand or be much more secure if it was a signed form showing that this advice had been given and these procedures had been appropriate.

**Dr Singer:** Yes. Certainly a benefit of it would be that for a post-op legal review, everything would be more neatly tied up, no question about it. However, in doing that I'm wondering how disruptive it would be to the communication act between health practitioners and providers. You see, I'm mostly recommending it not for the psychiatric or other prescribed health facilities where the risks, people say, are greater, but for the non-psychiatric or other prescribed health facilities where already there's a distinction between notification of the rights adviser. I'm just wondering whether a lower standard of proof regarding the written notice may not also be appropriate in that setting on the same principle of a graded rights response.

The thing clearly has benefits and harms and in weighing them, my overall impression is that it would probably be better to go with verbal communication and leave the onus on the health practitioners, if they so choose, as many do for procedures, to provide the written advice. Having

gone through this so many times with patients, what you say to patients and how you answer their questions is so much more important than what particular forms you stick in front of them, and sometimes sticking forms in front of them focuses their attention on the form and not on what you're saying.

That's really my concern, although I agree with your opening comment that in the long-term care situation, where I have no experience—I'm thinking of acute care—there may be reasons to go this route with written forms.

**Ms Jenny Carter (Peterborough):** Thanks for all the thought you've put into this. I just have a semipersonal question. As an older person, I do take this seriously. You said that the kind of form you are suggesting to us here could be filled in by a doctor and patient quite quickly. My personal feeling is I'd want a great deal of information before I'd be able to make a decision on some of these issues.

I wondered whether an organization like your own might come up with a handbook that gave information under each of these headings as to in what circumstances it might be needed, what the possible outcomes would be and so on, to help people make decisions on this kind of issue.

**Dr Singer:** Let me say firstly that I think the availability of such information is essential. In fact I think the main usefulness of living will forms and the whole living will movement is not the form itself or even what people put into it, but it's, if you will, the advertisement that you should pay attention to this.

Even with very rigorous laws, like the patient self-determination provisions of the Omnibus Reconciliation Act, 1990, in the United States, very few people actually complete the form, so the information is essential. Certainly we could provide it or various other organizations could provide such information. I think it would be important to prepare such information. There's a number of information packets prepared in the US for the patient self-determination act that one could look at.

However, it's important to modify the information to the person and to be able to answer the person's questions and say specifically how this affects you. For instance, in this form I say that if you have cardiopulmonary resuscitation there's a one in five chance you'll survive to leave the hospital. That is the average statistic, one in five to one in 10, from studies.

But if I know, for instance, that you have pneumonia or lung cancer, I can say that the number is not 10 or 20 per cent, it's closer to one or two per cent. If I know that you're young and healthy, it might be closer to 30%. So yes, there's a need for written information, but there's also mostly a need for tailored discussion of people with their health practitioners.

You certainly could develop information for disease or illness groups, if you will. The closer you are to knowing what illness ails a particular person or group, the better you can be at designing forms, which is why the dialysis-specific living will or the HIV-specific living will we've



developed seems more realistic to people in those situations than the general one.

As far as I can see, the greatest utility of the general one is commercial, if you will, to focus people's attention on the—I wouldn't say the need to do this but the need to consider doing this, depending on how much you want to control things when—

**Ms Carter:** A healthy person probably doesn't have much basis on which to fill it out.

**Dr Singer:** The real question is, when you actually get in that situation, will you want something else? A healthy person is more uncertain of the answer to that question, but I think a healthy person wouldn't likely change who he wanted to make decisions for him, so I'd advise him to have a proxy directive.

In terms of an instruction directive, the choice faced by a healthy person is, fill out the instruction directive, face the prospect of your own death and take the risk that you might have changed your mind, versus don't fill one out and don't have control over what the actual decisions are. I think healthy Ontarians should be presented with that choice and permitted to make it themselves.

**Mr Sterling:** Could I ask just one last question? You've had quite a bit of practical experience with this. Do you under any circumstances recommend that a person make a proxy directive as well as a living will, or just choose one or the other?

**Dr Singer:** My recommendation is that people make both, because they're complementary. I recommend that people make both unless there's a reason not to make one or the other. A reason not to make a proxy directive is that you don't have anyone you trust, which is why, by the way, I think that adding the public guardian and trustee as sort of a guardian of last resort or a proxy of last resort is helpful. A reason not to make an instruction directive is this problem of hypothetical situations. So I recommend that people make both unless they have a reason not to make one or the other.

When I see a patient with pneumonia in the emergency room, I ask him, "Who do you want making decisions for you if things get worse?" and I ask him about the ventilator decision, which is the one he'll face, and what he'd want. The information goes well together, because it permits me to ask the proxy about the wishes. "If Uncle Henry knew then what we know now, would his choice be the same or different?" If the answer is, "Different," then—by the way, I think that is the only reason not to follow someone's instruction directive, if you think he would have changed his mind, but that's a whole different kettle of fish. That's just the practical question I ask.

The answer to your question is, I usually recommend both unless there's a reason not to do one or the other.

**The Chair:** Dr Singer, on behalf of this committee, I'd like to thank you for taking the time out of your busy schedule to come and give us your presentation this morning.

**Dr Singer:** Thank you very much.

1120

#### SPARROW LAKE ALLIANCE

**The Chair:** I'd like to call forward our next presenter, from the Sparrow Lake Alliance. Just a reminder that you'll be allowed a half-hour for your presentation. We would appreciate it if you would keep your comments to about 15 minutes to allow time for questions and comments from each of the caucuses. I understand you'll be handing out your brief after your presentation. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Dr Paul Steinhauer:** I'm a senior staff psychiatrist at the Hospital for Sick Children, but I'm here basically as the chair of the steering committee of the Sparrow Lake Alliance. Have you people received a previous handout from me?

**The Chair:** Yes. It's in the package that was handed out last week.

**Dr Steinhauer:** In that package there's a description of the Sparrow Lake Alliance, so I want to take a moment, in case any of you haven't read that, to tell you a little bit about the alliance before I talk to the specific act.

The alliance is a three-year-old coalition consisting of members of 11 professions that work with children. We have psychiatrists, clinical psychologists, social workers, child care workers, day care workers, teachers, members of boards of education, judges, lawyers, nurses and paediatricians. All of us are getting together from our various service sectors. We have representatives of the health care sector, the education sector, the children's mental health sector, the child welfare sector and the family court system. We're working together in an attempt to promote health, mental health and the developmental prospects of all the children in Ontario.

We try to do this in a number of ways. We have a major emphasis on prevention and developmental supports. We're working towards creating families, schools and communities in which children can flourish. We're working with ourselves and with our colleagues in other service sectors to develop more responsive, more humane and more selective and effective ways of using services for children so that not so many children and families fall between the schools of the different service systems.

Third, we're trying to work to bridge the gap that separates one profession and one service sector and one ministry from another. We're working to establish a partnership between those of us who are actually working with children and the ministries that are planning and funding services for children so that together we can avoid the sorts of adversarial relationships that were so typical in the past, so that working together, we can serve children better.

Finally, we're about to begin a major education campaign, the goal of which is to increase community awareness of the fact that if we continue to let children down today, our society is going to suffer tomorrow in terms of increasing rates of vandalism and violence and increasing rates of illiteracy and illegitimate pregnancy. We're going to have fewer skilled employees, which is going to lead to less productivity, increased unemployment and increased



costs of welfare, unemployment, mental health treatment and imprisonment.

So this is who I'm representing, this group that has come together, putting aside their own particular interests to try to make things better for children.

Last week, I believe on August 6, the *Globe and Mail* reported on this committee's response to Dr Alan Goldbloom, who presented to it the second submission of the medical advisory committee of the Hospital for Sick Children. According to the *Globe and Mail*, following that presentation, the parliamentary assistant to the Minister of Health had responded that a majority of the presentations received last winter had indicated that most children between the ages of 12 and 16 are capable of deciding whether or not they should receive health care.

According to our research, this committee had received approximately 200 submissions regarding this legislation prior to May. Members of the alliance have reviewed these submissions and found that only five of them dealt directly with the issue of children's capacity. Only four addressed the issue of age of consent.

Three of these—the first a submission from the medical advisory committee of the Hospital for Sick Children, a second from the division of adolescent medicine of the same hospital and one from Justice for Children and Youth—were clearly concerned that (1) if adolescents under 16 could only be treated given the awareness and permission of their parents, or (2) if they knew that before they could be treated they would first have to go through an adversarial procedure to establish their capacity for consent, or (3) if health professionals were, or thought they were, at risk if they treated adolescents under the age of 16 without parental consent, then in all three of these cases, many children would be more likely to go without needed health care.

Thus all three of those briefs are concerned about 12- to 16-year-olds being deprived of necessary treatment if they were forced by the presumption of incompetence, prior to age 16, to obtain parental consent as a prerequisite for health care.

To improve such children's access to treatment, these briefs suggested lowering the age of presumed competence from 16 to 12, thus allowing the children to consent independently of their parents. None of these three briefs considered, let alone dealt with, the potential hazards to significant numbers of adolescents less than 16 who, if presumed competent, would almost certainly use their newly granted capacity to avoid necessary treatment.

To gather from this response that a majority of presentations indicated that most children between the ages of 12 and 16 are capable is surely misleading. The reason that this committee received no opposition last winter to the proposal to remove the age 16 presumption is because it was only in May that the tabling of new amendments made competency below 16 an issue.

Prior to these new amendments, most service providers and most others concerned for children had no reason to address this committee. Only in May, after the presumption of responsibility was lowered to age 12, did you begin to hear from us, and it wasn't just doctors who were con-

cerned; so were children's aid societies, so were school officials, so were dentists, and so was the Ontario Federation of Labour, surely an organization not known for its love of organized medicine.

Representatives of all of these groups have appeared before or written to this committee expressing their concern about the potential harm that will be done primarily and directly to children, but also indirectly through undermining their parents, if children below age 16 are free to refuse health care that has been prescribed by a responsible health care provider and that is considered in their best interests by their parents.

On page 3 of my previous brief to this committee by the Sparrow Lake Alliance, dated June 1992, I listed a number of conditions under which children who are otherwise mentally competent would, given the choice, frequently make irresponsible decisions regarding their own health care. Let me suggest two more, this time possibly a bit closer to home.

Suppose your own 13-year-old had a severe toothache or rejected medication for acute tonsillitis or a tetanus toxoid booster after having stepped on a rusty nail and refused medical treatment because of the anxiety and/or pain that would be involved. Would that be a responsible decision? Of course not. To give your child the health care he needed, how would you feel as a parent about having to go through a judicial hearing to officially label him incompetent just to be able to provide the care he needs?

Or suppose your otherwise well 15-year-old for no apparent reason suddenly panicked at the mere thought of attending school so that you couldn't get her out of the house in the morning, and that when you, as a conscientious parent, decided that the situation required professional help, she refused it. Would it make sense for this law to take away from you the authority you would need to ensure that she got the care she needed?

What makes this whole thing so difficult, of course, is that not all children mature at the same rate, and not all parents, especially those in conflict with their children, can always be counted upon to see their children's needs clearly and to put them first. Also, not all decisions are equal or responded to in the same way.

As a result of these factors, the Weisstub inquiry quite correctly pointed out that selecting any set age as the age of competence is somewhat arbitrary. Yet those who argued for lowering the age of competence quote Piaget, Weithorn, Grodin and Alpert and others to demonstrate that 13- and 14-year-olds are capable of reasoning about the same level as adults. But as I've tried to demonstrate through my examples, there is more to decision-making than the capacity to think rationally. We agree with Weisstub that competence is a complex construct requiring not just rationality, but the ability to simultaneously deal with strong emotional states, maturity levels and social pressures, while striving to remain rational and objective.

1130

Also, it's well known that early adolescence is a developmental stage characterized by frequent emotional storms that often overwhelm the capacity for reason. The Group for the Advancement of Psychiatry in 1989 pointed out



that the universal developmental task of moving towards autonomy leaves many adolescents in frequent conflict with authority and unduly susceptible to the influences of peer pressure.

As Hudson, Hornick and Borrows stated, "Many young people requiring counselling are unable to provide consent because of the very nature of their problems." For example, the Young Offenders Act gives children of 12 the decision as to whether or not to accept a judicial proposal for a therapeutic disposition. Such children almost never choose therapy, and since the judge cannot overrule them, they almost always go untreated. This is equally likely to be so for many children who need treatment but cannot recognize or act upon that need. Many of them will do without the treatment they need if the age 16 presumption is removed.

We understand and support the intention behind these proposed amendments. Children below age 16 who would likely be deferred from treatment if parental knowledge and consent were a prerequisite, should certainly be able to receive the care they need. In such cases, rigid insistence on parental consent would be an obstacle, not a protection, for them. But in your attempt to help them, please do not make the error of moving to an age 12 presumption, thereby predictably depriving of health care others whose condition will not allow them to consent to the care and treatment they need.

There is no inconsistency in our position. We support lowering the age 16 presumption when not doing so would deprive specific children of necessary treatment, but not doing so universally, thereby undermining parents' attempts to advocate for those of their children unable to advocate for themselves.

That is my formal presentation. I would be glad to speak to any questions.

**Mrs Sullivan:** As you know, we as a committee have been battling with this issue in the first round of hearings and, of course, now we're faced with a very different view, I think, of the problems than we heard in the first round of hearings. I suppose that coming to a compromise in terms of maturity versus competence and the age 16 presumption is something the government is going to have to put its mind to very carefully.

Is it your view that if the government moved back to the original form of presumed capacity at 16, as it was presented in the original version of the act, young people who were subjected to that—say at 14—could in fact receive advice and counselling on sexually transmitted diseases, on other sexually related problems and in fact could receive perhaps even therapeutic abortions?

**Dr Steinhauer:** As I understand it, the situation exists under the Child and Family Services Act now for them to receive counselling at the age of 12 without parental consent, the only onus being on the counsellor, at the soonest point that seems appropriate, to raise with the child the possibility of involving the family in some way in the discussion, and that might and it might not be appropriate at other times.

Doctors and other health care providers are often prepared to do what the child needs, basing this on the common law that if they basically do a reasonable assessment of the maturity level of the individual youngster, they are not going to get into too much trouble.

The problem is that you have many health care providers who are frightened at the prospect that if in a particular case they were to demand consent from the parent, they would lose the confidence of the child and they would lose the opportunity to work with that child. Then what happens is there are many doctors who will back off. They don't recognize the protections that are there for them in the common law.

My feeling is that if the health care professionals were made more aware of the fact that there is a certain leeway allowed them in the common law, it would be quite possible to provide the release so that health care providers could dispense with parental notification and consent if they felt that would be against the best interests of the child involved, but to rely upon it in situations where it was needed to strengthen the parents in a family that hasn't broken down and where the parents are advocating for the best interests of the child.

**Mr Jim Wilson:** To follow up on that, Dr Steinhauer, the model that you're suggesting would involve a release and a judgement call by the physician.

**Dr Steinhauer:** The release and judgement call by physicians and health care personnel is going on all the time as it is. If this were made explicit, it might help a certain number of health care providers feel a courage they should have possibly, but that so far they lack to rebut that presumption of incompetence when it is in the interests of the child they are trying to serve to do so.

**Mr Sterling:** I'm getting a little bit confused with regard to the argument we're hearing now in terms of people who are objecting to the taking out of the presumption of incompetence under the age of 16. I'm not sure where the demarcation is, whether it's 16 or 15, but let's say that's what it is. What I don't understand, from the witnesses and yourself, is under the old rule, when there was a presumption of incompetence, was there a balance in other parts of the legislation, the advocates etc, which made the health care providers comfortable, because the presumption was there?

Basically, as I understand the legislation now, by taking out that section altogether, section 8 of Bill 109, we're thrown back on the common law. Therefore, I hear people coming forward, like yourself and children's aid societies, that I empathize with. Are you and they telling me that you're not satisfied with the status quo, the common law?

1140

**Dr Steinhauer:** I think that people like myself, people in the child welfare field and people in the children's mental health field, were satisfied basically with the status quo. However, they were recognizing that some of our colleagues in paediatrics and people who were doing more health care counselling, particularly in the sexual abuse area, in the area of sexual counselling, in the area of sexual disease, in the area of planned pregnancy, were feeling



they didn't have the freedom to get involved with youngsters in the way they needed to be able to get involved with them to help them, because they felt they needed parental consent first.

Now, of course, there have been some paediatricians and family physicians who have been doing this all along. However, I think the primary concern of people—for example, the two briefs from the Hospital for Sick Children last winter—was that they, as paediatricians, were having difficulty at times involving teenagers because either they felt the teenagers didn't feel they could come to them without having to get parental consent or they had had experiences in the past with doctors who had felt that they couldn't counsel them without their parents' consent.

I think they were pushing for something that they felt would help that particular group of children, and I think that while coming up with these amendments maybe solves that problem, the legislation promises a much greater problem with another group of children.

**Mr Sterling:** But as to that other group of children and the health care providers and the social workers who were dealing with the other people who are not as satisfied now under the amendments, am I reading them correctly as saying, "We saw Bill 109, as it was originally presented, as giving us more control over those decisions for the young person from 12 to 16 and we like that because we feel we can treat these people to their best interests"? Now that it's backed off to 12, they're coming to us and saying, "We don't like the fact that we are not going to have more power."

As I read Bill 109 now, as it was originally presented it gave the CAS more power. It gave health care providers more power than they ever had to deal with that age group and that's why they liked it. Now we're saying we want to put it back to where it was and we're hearing them complain.

**Dr Steinhauer:** My concern is that the proposed amendment takes power away not from health care providers, but I think from parents. That is what my primary concern is, that the parent should be able to be the parent as long as the parent is able to meet the needs of the child.

**Mr Sterling:** I understand that, but is there any difference for a parent today without Bill 109 as opposed to the introduction—

**Dr Steinhauer:** I think so, very definitely. Let's take the two examples I gave you today. Suppose your child had been the one who had stepped on the rusty nail or had the tonsillitis and suppose you, as a parent, decided that child needed treatment and suppose the child said, "No, absolutely not, I refuse." Then, according to the amendments in Bill 109, one would have to go through a judicial procedure in order to demonstrate that the child was incompetent and to get the permission to give that child the care the child needed. To me, that is going to be undermining very many families.

**Mr Sterling:** Under the present law?

**Dr Steinhauer:** Under the present law, that does not become an issue.

**Mr Sterling:** How do you get the child to take the needle?

**Dr Steinhauer:** I think under the present law the parental authority is not undermined. There may have to be an issue within the family but the family can usually work that out and if the family gets into too much trouble it can often get help from a family doctor, from other resources outside the family in resolving it.

I'm not aware that there is a problem in that sort of issue with the current legislation, but there would be. In many cases where the parents are dealing with the irrationality in a younger teenager, where the irrationality is a function of the child's developmental stage or strong moods temporarily overwhelming the child's judgement, in situations like that, I think the present legislation gives the parents time, but if the legislation comes down and says, "If a kid says no, then no is no," to me, that is an intrusion by the state into the affairs of the family and undermines the position of parents at a time when I think enough parents are enough under siege anyway. I don't think they need this kind of intrusion.

I think there are times in the life of normal teenagers, particularly younger teenagers, even leaving out the question of health care, where the younger teenager often requires the stability of a parent to help that child keep the various swings and keep a certain amount of perspective. I think you undermine that with this amendment, by dropping the age of presumed competence to 12.

**Mr Drummond White (Durham Centre):** I want to congratulate you on your presentation. You've put some very difficult issues, and all the vicissitudes that go into treatment, very well. As a parent of adolescents and as a family therapist myself, I have a couple of questions. I tend to agree with you about the presumption of competence with adolescents not always being verified or verifiable. It's easy to see, theoretically. With my kids, I'm not always sure it's there.

There were a couple of things I wanted to ask you about here. I've worked as a family therapist and with adolescents for many years. After the Child and Family Services Act, as a professional social worker my practice was impacted because at that point I was allowed to work with youngsters between the ages of 12 and 16 without parental consent.

What struck me was that when they have the option, the opportunity of seeking treatment, these youngsters do, and as you're saying, many people in your hospital also thought that would be an important option for them. The presumption that there might be refusal is realistic for some kids, as you mentioned, but I think most would be empowered, enabled, most would have the opportunity they previously had been denied. That's the one aspect, and I think you picked up on it yourself.

But the other concern I had was that with the law as it stands now, if someone is compelled to go into treatment, my experience is that those kids don't respond really well. At least, my own treatment with youngsters was based upon a contract, a consensual arrangement. I'm wondering if you could comment with regard to those youngsters.



**Dr Steinhauer:** I'm glad you raised that. I have had a somewhat different experience. I think it's true that wherever possible it makes sense for any therapist to try to get an understanding consent on the part of all people involved, but I have seen, and colleagues have reported to me—actually, in that first brief I sent to you I reported in some detail a situation of a young boy who was brought to me under protest; the only way that kid and some other young adolescents have to prove that they are individuals and prove that everything is fine, that there are no problems, is to protest like mad, but they work from the moment they get in the door.

I've heard colleagues who have worked in inpatient units talk about the same kid who was protesting like mad about having to come in three or four weeks later telling other people, "This place is really good, they really help you here, they really understand things." I think there are some kids, particularly at this developmental stage, who need to protest getting into treatment but who, once there, are able to form an alliance so that you can work with them.

At the same time, I admit to you, there are some kids where that doesn't happen. If you don't manage to form that alliance, then you may get nowhere with that child and you may end up towards stopping. I don't know about you, but I can never predict in advance which ones I may be able to seduce into an alliance so that we can then work together towards the solution of their problems. If I had to write off anyone who said right at the very beginning, "No, I'm not going to come," I think I would have lost a lot of kids whom I've been able to help significantly.

1150

**The Chair:** Mr Malkowski, one final question.

**Mr Malkowski:** Thank you for your presentation. I want to clarify about the Ministry of Health amendments, so I will ask Jutta to clarify.

**Ms Jutta Auksi:** I want to clarify a point that I think Mr Sterling was raising with you a little earlier. The difference in the bill as amended, compared to the bill before, is maybe not quite as dramatic as perhaps you are suggesting.

The amendments to the bill do not set the age of presumed capacity at age 12. The reference to age 12 has nothing to do with the finding of incapacity or capacity *per se*, but rather at what point a person would be entitled to certain information about their rights should they be found incapable by the practitioner.

The removal of section 8 from the bill as it was has removed any presumption of capacity or incapacity, so it's entirely up to the health practitioner to determine whether or not a person is capable of giving a consent on his or her own behalf. In that regard, I think it's really not that different from the common law as it is now, in that parents under the common law would not have the right to impose their treatment decision on a young person who is mentally capable of making that treatment decision for himself or herself. That parental authority doesn't really extend to that extent under common law now, nor would it under the proposed bill.

What I'd also say is that under the earlier version of the bill, with a presumption of incapacity under 16, that presumption was still rebuttable. So even under the earlier version, if a 13-year-old came to a practitioner and there was a presumption of incapacity but the practitioner found him or her to be capable, it didn't entitle the practitioner to rely on the parents' consent over the objections of the young person.

**Dr Steinhauer:** I wonder if I understand the law incorrectly. It was my understanding that parents did have the right to insist on health care provided it was in the best interests of the child; if you were at a point where the parents' interests diverged from those of the child, under the common law they did not have the right to insist upon that child's involvement in treatment. Am I incorrect there?

**Ms Auksi:** I'm not a lawyer, but the lawyers tell me that's incorrect.

**Dr Steinhauer:** I'm not a lawyer either. My authority for that is my reading of Weisstub, and I thought that was what Weisstub was saying.

**Ms Auksi:** I don't think so. Actually, I was going to mention also that in Professor Weisstub's book on mental competency, of course his recommendation was that there be a presumption of capacity at 14, based on empirical evidence he had looked into saying that most children would actually have acquired the necessary mental capacity at that age, and in fact a great many would have by the age of 12. There is some idea that people mature at different rates.

**Dr Steinhauer:** Yes, I'm aware of Professor Weisstub's coming to that position. I think it came as a bit of a *deus ex machina*, and I tried to review this in my presentation this morning. While he talked a great deal in his book about the fact that there are a number of people who say that at the age of 14 or 15 children cognitively are capable of rational thought at a level fairly similar to that of adults, I think the other issues I tried to bring in—the issues of the conflicts specific to early adolescence, the issues of the mood swings that are fairly typical of early adolescence and the susceptibility to social pressures—very much tend to impact on the capacity to be rational, especially in times of crises, which is why I found his suddenly deciding on age 14, as if the only thing involved were the question of the capacity for rational thought, to be rather surprising.

**Ms Auksi:** I think it's important too to remember that in the definition of "capacity" in the bill, which again reflects the common law concepts, it's not only understanding the relative information and the consequences, but appreciating the consequences. In the Consent to Treatment Act, it is a decision-by-decision issue so that if, for example, an individual who may be generally considered capable of making a wide range of decisions made a particular decision because of his distraught condition of mind or the trauma of something that's happened, perhaps lack of maturity would be a consideration there, because children do not develop in the same ways. I think some of

this would really come down to an implementation issue of how the assessment of a young person is conducted.

Certainly this issue has been brought to our attention. Of course, it happens all the time out there that practitioners encounter young people coming to them for health services without their parents, and practitioners are having to decide whether they are mentally capable enough. In part, that means are they mature enough to appreciate the consequences of what this treatment would do for them? The bill tries to codify that.

**Mr Sterling:** Mr Chairman, I really believe that in order for the committee to reach a conclusion with regard to section 8, which has been removed, it's very important for me as a member of this committee to understand what the existing common law is with regard to treatment of immature adolescents. I was wondering whether you might be able to obtain a legal opinion. I've heard Dr Steinhauer give his interpretation of what he understands the common law to be. I've heard the health care policy person talk about a difference of opinion as to what the common-law status of an adolescent is. From my point of view, I would like to fully understand the control of a parent over an immature child in terms of obtaining treatment.

**The Chair:** Would you like that written or oral?

**Mr Sterling:** I would like it written, and I would like to know who it's from. We might want to obtain outside counsel after I see the inside opinion.

**The Chair:** Okay. I'm sure that can be arranged.

**Mrs Sullivan:** I concur 100% with Mr Sterling on this point. I think it would be useful to have both internal—indeed, my recommendation would be external counsel on this matter. As you know, counsel have appeared before the committee who specialize in health care law and who could be engaged by the committee. I believe there's probably adequate funding in our committee budget to do that. Certainly we hope to hear from Mr Sharpe during the course of clause-by-clause and perhaps even in advance of that. We've certainly been around the garden gate on this issue and I think we have to have a lot more information than we have.

**The Chair:** We'll have to call for a subcommittee meeting on that as the Board of Internal Economy hasn't approved the budget for this committee. Perhaps we could set up a subcommittee meeting to discuss this.

Dr Steinhauer, on behalf of this committee, I'd like to thank you for taking the time out to give us your presentation this morning. This committee stands recessed until 2 pm this afternoon.

The committee recessed at 1159.



## AFTERNOON SITTING

The committee resumed at 1409.

**The Chair:** I call this committee back to order. Just a few announcements: We'll deal with the subcommittee report at the end of this afternoon's proceedings. A few changes in the schedule: First of all, we'll be going with the Regional Geriatric Program of Metropolitan Toronto, then we'll go to the Easter Seal Society and then, because of a conflict in some correspondence that went out, we'll have the Right to Life Association of Toronto and Area after that, which we had scheduled for Thursday, I believe. They will be giving their presentation today.

REGIONAL GERIATRIC PROGRAM OF  
METROPOLITAN TORONTO

**The Chair:** I'd like to call forward our first presenters, from the Regional Geriatric Program of Metropolitan Toronto. Good afternoon.

**Dr Michael Gordon:** Thank you very much for allowing the modest switch in program.

**The Chair:** Just a moment, please. This is just a reminder that you'll be allowed half an hour for your presentation. The committee would appreciate it if you would keep your remarks to just about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you are comfortable, could you please identify yourself for the record and then proceed.

**Dr Gordon:** I am Dr Michael Gordon. I'm a geriatric specialist at the Baycrest Centre for Geriatric Care and I'm here on behalf of the Regional Geriatric Program of Metropolitan Toronto.

If you haven't received a copy of my brief, it will be copied and submitted to you later. It's entitled *Advocacy Legislation—An Expensive Experiment*. I presented at the earlier hearings about the legislation, and this is the follow-up after the amendments.

The hearings were completed in 1992, and as an outcome of the hearings a number of amendments were derived from the input of the various parties who submitted briefs. Of course, the plan now is to review the amendments and have hearings again.

I was concerned about the effect of the previous draft of the law on persons suffering from cognitive impairment. As I review the amendments to Bill 74, I note that many of what I believed at that time to be the most onerous clauses have been removed or modified. For that, I am grateful. Therefore, as it stands now, I believe the legislation is no longer one that will actively impede the care of persons with cognitive impairment, nor will it actively undermine the relationships between families and health care providers, which was the major concern of the previously unamended legislation.

However, for me and the people I represent, the issue remains, what positive benefits does this legislation and its impact on substitute decision-making and consent to treatment bills offer to persons with dementia and their families? Rather than being onerous, the legislation is merely a cumbersome and unnecessary layer of administration that

will add little to the care given to older individuals with cognitive decline and do little to assist families in fulfilling their care-giving role. We should therefore seriously question the basis for the legislation altogether. I'm speaking specifically about Bill 74 at present.

The question I'm asking is, who needs help? That there are persons with physical and psychiatric disabilities who could benefit from advocacy is clear. Whether the nature of need and the context of assistance pertains to persons with dementia is not as clear. Whether a new administrative structure to assure that needs are recognized and addressed deserves to be questioned.

There is no question that there are many older individuals in Ontario who suffer from cognitive impairment. A number do not have dedicated care givers or have care givers who are not committed to their wellbeing. They could potentially benefit from an objective and responsible advocate, not a rights adviser. The role of an advocate in this circumstance would be to ensure that proper actions are being taken to ensure that person's wellbeing and, if necessary, take on the role of surrogate decision-maker if there is no one suitable to carry out this role.

The concept of a rights adviser to a person with dementia has little meaning as conceptualization and reason become compromised. What I am saying is that to explain to somebody what his rights are when he has difficulty understanding basic communication is really, I think, not a particularly useful endeavour.

For many individuals with dementia, there are family members who are dedicated and committed to their wellbeing. What is lacking in the structure of care is not the protection of rights but the facilitation of access to care and options of strategies and treatments that will assist the family member in assuming care and fulfilling his or her designated role. There are many barriers to care and inadequacies in the present system that will not be addressed by ensuring that the rights of the individual are respected. Rather the legislation may misdirect the focus to rights protection and away from adequacy of care alternatives and options for the person and his family.

The creation of a new bureaucratic structure to solve the problems of some people who might be truly vulnerable and at risk appears to be an excessive and unwanted use of valuable and limited resources. With the creation of this new administrative structure, one can anticipate further developments that may be self-sustaining and contribute little to the real care problems that are central to the issue and of greatest concern to family care givers.

**Basis for programmatic development:** Within the practice of medicine, it is now acceptable to most government agencies responsible for funding that before funding is approved the basis for a programmatic initiative must be documented. The criteria for accepting a program as worthy of development include a definition of the problem; its true extent; the impact and/or result of the present situation; the proposed solution; the rationale and expected outcome of the solution, and the cost and relative benefit



for the costs as well as some measure of utility as compared to other uses of the same resources. From our understanding of the data that have been presented so far, no such proposal has come forth to support the presently conceived Bill 74.

The proposed advocacy legislation and the development of the Advocacy Commission is based on a number of assumptions. The data that have been made available by the government do not appear to adequately support the premise on which the program is founded. The definition of a number of so-called "vulnerable persons" has never been clarified. It appears to be based on the potential number of vulnerable persons, depending on the definition. If for the cognitively impaired "vulnerable" implies having the diagnosis of a dementing condition, the number will of course be high. If "vulnerable" is characterized by cognitively impaired individuals who do not have a dedicated and committed care giver, the number will clearly be much smaller.

Depending on the true number of vulnerable elders suffering from cognitive decline, the impact on the proposed legislation may affect many or relatively few people. Although other categories of individuals with psychiatric and physical disabilities may benefit somewhat from the proposed legislation, it is the elderly and others with cognitive impairment and their families about whom I am especially concerned. For them, the advocacy legislation offers very little of substance and will merely add another layer of administration and costly bureaucracy to a system that already has difficulty meeting the substantive needs of this ever-growing segment of the population.

Testing the premise: Before a commitment is made to make available funds to fulfil the mandate of the advocacy legislation, I propose that a proper study be performed which, first of all, adequately and thoroughly documents the true numbers of really vulnerable individuals. Moreover, I suggest that a pilot project be performed at a number of designated sites to observe and critically analyse the impact and relative benefits and drawbacks of such an advocacy system on the care-giving activities as they affect individuals with cognitive impairment as the cause of their being defined as vulnerable. I predict that for those whose major problem is cognitive impairment, the advocacy legislation will benefit very few and thus will be a costly add-on to the health care system.

If indeed the statistics and the outcomes of pilot projects indicate that there is a true need and that the benefits are tangible, measurable and cost-effective, the program should be implemented fully, as would any other similar program that affects the health and wellbeing of individuals. If the studies demonstrate that there are parts of the program that are redundant or irrelevant, they should not be implemented or funded.

Conclusions: There is no question that the intent of the advocacy legislation is beneficent. This, however, should not be considered sufficient to allow the government to embark on a program of indeterminate benefit. No new major health care initiative would be allowed to be funded based on good intentions. My concern is that intentions may have little to do with outcomes, as has often been

shown in other areas of health practice and policy. The bills dealing with substitute decision-making and consent to treatment deal substantively with important issues that are known to be a problem in health care practice and supportive of many of the needs identified by health care professionals and families. It is the role of the advocates or rights advisers that appears to be an unnecessary addition to the proposed changes.

I recommend that Bills 108 and 109 be allowed to proceed with appropriate modifications without being dependent on Bill 74. For the latter, a study should be undertaken to document the extent of the true, so-called vulnerable population. If it is agreed that the population at risk merits such legislation, a pilot project should be implemented to evaluate whether the proposed structure will answer the needs of the identified group and whether or not a simpler and more cost-effective system might not be built upon the already existing system. The latter might include an augmentation of the mandate of the office of the public guardian, the coroner's office, the legal aid system. With a modest increase in funding these agencies might be able to fulfil the identified needs of vulnerable persons and their families.

At a time of scarce financial and human resources, we should understand the reasons and implication for policies that affect the health care of our population, and we should carefully measure their impact. The advocacy legislation has not been demonstrated to be necessary in order for those in Ontario who need assistance and dedication to receive it with dignity and humanity.

1420

**Mr Jim Wilson:** Thank you, Dr Gordon, for your comments. Many of the arguments in terms of cost-benefit analysis and such that you put forward are reflected, I think, in the earlier transcripts of these hearings, where my party and the Liberals often asked those questions of the government. But given that we've had a set of amendments come in and given the government's intention to proceed, perhaps you could tell us, if the legislation is to proceed with the amendments as you now understand them, what effect that would have in your day-to-day life as a physician, I gather, at Baycrest.

**Dr Gordon:** I think it will still add, even though not as onerously as in the past fortunately, a layer of interaction that I don't believe is necessary, which has to be translated into somebody's time, effort and cost, no matter how you put it together. If you have to invoke another layer of involvement that costs something—be it time, money, however you want to translate it—I don't believe it will add anything to the needs of the person and the family.

The vast majority of people we see in our practice—and one might say I have a skewed population, but in fact I've looked into it in terms of geriatricians and neurologists who deal with dementia—do have people who are connected to them who want to care for them. What they're looking for is systems of care giving. The rights issue is really a relatively minor issue unless you're assuming that this group of people really doesn't care and somehow has some kind of alternative reason for being



involved, which I think would speak very poorly of our society, because then you'd have to suspect everybody who's a care giver of somehow having an ulterior motive.

What they need is a way of facilitating the delivery of services, because most of them are struggling with the delivery of services. To bring in another layer that somehow will inform people that they have the right to appeal and can appeal really will add nothing to their daily activities and, I believe, will just add, because to have the structure, you're building an infrastructure that requires resources. I don't think it's required, because we do have a system already in place that would allow for that.

**Mr Stephen Owens (Scarborough Centre):** Thank you, Dr Gordon. I want to suggest that you may be swimming upstream against a river of precedent in terms of your views that the advocacy legislation is not needed. As a matter of fact, this morning I was dealing with a situation in my own riding where if this legislation was in place, it would certainly have prevented a lot of pain that a particular family has been going through with respect to the treatment a constituent is receiving in a nursing home.

I think that I am at variance with your opinion that rights advice adds only another layer of bureaucracy to the process. I think that in terms of some of the more spectacular results of individuals who had not been advised of their rights nor had that advice made to them that we've seen in the newspapers over the past year or so, had legislation of this type been in place, perhaps we might have avoided some of the cases that we've seen. We don't live in a perfect world and not all nursing homes, not all geriatric centres, are perfect. I would suggest that from time to time Baycrest may even have some difficulties.

**Dr Gordon:** God forbid.

**Mr Owens:** God forbid. But I think that in terms of us living in the real world, it's legislation like this that is needed to protect people who are vulnerable. In terms of being able to have personnel available to explain rights to individuals, it certainly doesn't add just another layer of bureaucracy; I think it's an integral part of the care an individual receives. Having the family involved in that advice is important as well.

**Dr Gordon:** I have no problem with the issue of advocating; quite the opposite. I've been a very strong proponent of advocacy, for people taking the position of protecting people and coming to their need. What I'm concerned about is that I think in order to accomplish that goal one doesn't have to build a new infrastructure. We have systems that would allow for that if they were enhanced, without having to create a new infrastructure.

I believe one could come to the aid, be it of an individual in a long-term care facility or in his or her home, which is certainly justified—I have no issue with that at all—without having to create what I look at as sort of an almost new industry. I believe there are people who are willing, able and desirous to come to the aid, and there are systems in place that could be augmented to do so with not only less expense but with a simpler method than what is being proposed in this legislation.

**Mr Owens:** For instance, whether it's clinic lawyers or private bar lawyers who accept legal aid certificates, it's my view that the legal aid system is struggling now to fill its own mandate, and to add yet another layer of duty to legal clinics, for instance, would be onerous. Having a system of advocacy that's separate and apart from the whims of government I think is important as well.

**Dr Gordon:** Let's put the legal aid aside. That's a special kind of intervention that's very legalistic. We have an office of the official guardian. We have a coroner's system that has long-term and geriatric—

**Mr Owens:** By the time it reaches the coroner's system it's too late.

**Dr Gordon:** That's because the mandate of it has been to deal with it after the fact. The mandate has changed and the long-term and geriatric committee is dealing with systematic issues. What I'm saying is that if you talk about the cost of building a new system compared to the cost of augmenting already existing systems, I suggest you could get the same thing accomplished more simply for less money. Obviously, if you gave legal aid more to do now with the same budget, it would die.

I don't know what the proposed cost has been—I haven't been able to get a good figure—but let's throw out \$30 million, \$40 million, \$50 million. What could you get for half that money by augmenting what exists?

There was a recent publication from British Columbia that looked at that process as a way of solving—nobody's quibbling with the need for defined advocates for certain situations. I'd be the last person to quibble with that. I've spent 18 years doing it, not necessarily in my medically professional state but in my commitment to the care of the elderly. Nobody quibbles with that. It's a matter of how you accomplish that role in the most efficient, effective and reasonable cost-effective manner.

Nobody's quibbling with the need for advocates or the need to make sure that people who are either being poorly treated or are at risk of being poorly treated are looked after. That's not an issue.

**The Chair:** A brief question, Mrs Carter.

**Ms Carter:** I really have to agree with my colleague on this. I think you're shifting the grounds on which you're opposing this. You're saying it's not needed for people with dementia because they presumably don't have any opinions, and I would disagree with you on that. I think we do have the non-instructed advocacy, which has been clarified in the amended version of the bill, that can pick up on people in that category who have been neglected.

You're also saying that in general there is a need for advocacy but that it's being met. I think the basis on which we initiated this bill was that this need is not being met. What we're offering is different to anything that was being done before. We've always had volunteers and so on who would help people in distress. We're building on that. We're keeping that. We're not saying we don't need those people any more, but we are setting up an organization which is much more at arms' length from any employer so that people who are advocating will not be running into conflict-of-interest situations and criticizing the organization,



whether it's a ministry or whatever that's employing them, and helping them in that much more disinterested kind of way.

We're also giving these advocates, whether they're voluntary or not, powers that they don't at the moment possess to be effective, like to gain entrance and to talk to the people they need to talk to and so on.

You said that the vast majority of people don't have this kind of need, but what about the rest? There are those others who don't have family, who don't have friends, who are neglected, who do fall through the cracks. We need people with powers to be able to do something about that and I think this is what the act is suggesting.

Also, it's not a vast bureaucracy. I believe the suggested number of advocates is 150, which, spread over Ontario, doesn't seem like a large number. I'd like your comments on that.

1430

**Dr Gordon:** It's hard because I haven't seen hard figures. The numbers that were bandied about, certainly in the media, were large amounts of money by any way that I would measure how money is going into the system now.

I think there are organizations that exist now that could be enhanced to accomplish this role. I don't understand why one has to create a new organization in order to do it. One can meet the needs and rights of those people who do not have dedicated care givers.

You mentioned certain powers such as rights of entry. That's another issue I have major concerns about, because I think the rights of entry are really quite extreme considering the situation that one can enter without a warrant if one has a suspicion. That's a pretty extreme privilege that very few people have, even in law enforcement organizations, so I have concerns about that.

I have concerns about the fact that there's not a sort of professional body to which these people are accountable. But those are almost getting into the nitty-gritty of the legislation. Once you get into that, there's an assumption that the legislation's already okay, and if we can only work out the rest, then it would be fine. I believe the legislation is overdone, if you want to call it that, in terms of what has to be accomplished. I believe what has to be accomplished can be accomplished much more simply, less expensively, and can meet the needs of the people who require the services of an advocate.

For those with cognitive impairment, perhaps in very early stages there may be some ability to make certain kinds of judgements, and impairment isn't necessarily global; we're all aware of that. But very quickly the issue becomes, "How will I and my family get the care that I need?" more than, "What are my legal rights?" If we look at the desperation that exists now, it's really in the receiving of needed care as opposed to what my rights for care are. You can have the rights for care and still not have it available because it doesn't fit in the system or there's not enough of it to go around.

**Ms Carter:** But how would you amend the existing system to pick up those people who are still falling through the cracks?

**Dr Gordon:** One could enhance the role of the public guardian. One could change the mandate of, for example, the geriatric coroners or whatever. You could say, "You have the mandate to deal proactively."

I had a situation some years ago in my own institution where there was a contentious issue, and I knew that when the person died, it would become a coroner's case. I knew; I've been in the system long enough. I called the coroner and said, "Is there any way we could have a pre-mortem?"—in other words, have the coroner's case beforehand, while it's still fresh in everybody's mind, rather than afterwards. He said that of course he couldn't because the law doesn't allow it; that's not the mandate.

I understand that's the law and the mandate. If you changed the mandate and you said that you could evaluate similar situations—at risk, contentious—beforehand, there's an infrastructure already there and there are people and you could add rather than rebuild. Again, if you look at the BC document, that's the approach they've taken: "Let's build on what we have." We have a lot of very good and dedicated people. We have people who have been doing this but have been limited for one reason or another. Allow the mandate to expand to include it.

I'm willing to suggest that maybe I'm wrong on this. Why not do this as a pilot project where you actually examine it in detail? There's a big difference between legislating across the province and saying, "Let's try this out." We can look at the issues that are involved, what the concerns are, what the barriers are, what the real costs are and what the need is. You could take a couple of small, nicely designated areas that have geographic value. It's very hard to do it in a large metropolitan area, but you could do it in smaller communities and you could try it.

When we're faced with this in medicine, that's what we do. If we're not sure if it's worth introducing a universal policy for something, you look at it as a pilot project. You look at the cost-benefit and at the end you make recommendations based on that.

That's what my suggestion is. I'm prepared, if that's the case, to be found not correct in my predictions. Let's demonstrate it before we set up a whole new whatever you want to call it—bureaucracy, administration, industry—which commits the government to, I think, a large outlay of money. Let's try it out and test it. It's not that complicated to do.

**Mr Sterling:** I just want to say that I'm amazed Mr Owens believes this is going to avoid the use of lawyers. I've got to tell you something. This is going to be one of the greatest make-work schemes for the legal aid system and lawyers that has ever been dreamed up in this province, because where do you think the advocates are going to go with the rights of patients who they're acting for after they come to the end of their line with regard to dealing with minor officials? They're going to create a lot of work for a lot of lawyers. I can guarantee that.

Once you create an Advocacy Commission, people to advise people of rights, the next step is, "How do I exercise those rights?" These advocates are not going to be able to go into the courts and exercise those rights for the patients.



I guess one of the most impressive submissions I heard was by the adult protection service workers of this province. There are about 175 of them. Their principal concern in coming in front of this committee was, "Look, we spend 40% of our time advocating now on behalf of people who are vulnerable, who have been sent out of our institutions." Their concern was not about getting more rights to advocate. Their concern was getting ministries to answer their requests for services. It had nothing to do with getting more rights or more advocates out there.

The problem for the government is, are you going to spend money on more people bitching and complaining and asking on behalf of other people or are you going to provide more money to provide services for the people who need them? That's the issue.

We've had a great deal of trouble with this legislation. Nobody can argue against advocacy. Nobody in his right mind can argue against advocacy, but you sure can argue about the economics of this and this is nothing—

**Mr Owens:** Is that what you call advocates, bitches and complainers?

**Mr Jim Wilson:** But if the advocate says she needs a chronic care bed, where are you going to get the chronic care bed?

**The Chair:** Order. Mr Sterling has the floor.

**Mr Jim Wilson:** You've taken them all out of Simcoe county, for God's sake. My grandmother's on an eight-month waiting list for a bed. That's where the money should go.

**Mr Sterling:** Our continual concern with this whole piece of legislation has been that it is—

**Mr Jim Wilson:** I'm advocating for her and there are no resources.

**The Chair:** Order, please. Let's keep things under control. Mr Sterling has the floor.

**Mr Sterling:** I agree entirely with the witness in terms of saying we should, in all honesty and consciousness, try to do this in the most reasonable and most economical way possible for the taxpayer, so that we can provide more services for more vulnerable people. That has been our concern with this legislation. I can only come to the conclusion that this Advocacy Commission is nothing more than a political ploy. That's the bottom line of it. It is a political exercise and has nothing to do with helping out vulnerable people.

**Dr Gordon:** Since I'm running out of time, I want to remove myself from the political forum because I'm really apolitical in this. I have dealt with all parties equally in my professional experience. I am looking at this as I would look at any initiative that has a clinical impact on people. What we've all been trained to do lately, more so than ever, is to examine it, examine the benefits, the costs and the alternatives. I don't believe this legislation, even with the amendments, measures up to what we are now expected to do in everything else that we do, and I'm very concerned that a commitment would be made to do this without the kind of trial and assessment that might give us a proper answer. Those are my final words.

1440

**Mr Sterling:** I'd just like to withdraw two words I used during my outburst, and they were given in a motion, and those were the words "bitching and complaining." I used those in perhaps the wrong context. I intended to indicate the idea of utilizing the system in terms of taking up the time of the system to express concerns of people, which, while it may have some benefit, doesn't have the same benefit as providing hard treatment.

**The Chair:** Thank you, Mr Sterling. Dr Gordon, on behalf of this committee, I'd like to thank you for taking the time out this afternoon and giving us your presentation.

**Dr Gordon:** Thank you.

#### EASTER SEAL SOCIETY

**The Chair:** I'd like to call forward our next presenters, from the Easter Seal Society. Good afternoon. I'll just remind you that you'll be allowed a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Mr Alan Dawson:** Good afternoon, ladies and gentlemen. My name is Alan Dawson, and I thank you for allowing me the opportunity to speak to you on behalf of the Easter Seal Society. You may recall from my oral submission to this committee on February 18, 1992, that the Easter Seal Society is a provincial, non-profit organization dedicated to helping almost 8,000 children with physical disabilities in Ontario; 7,200 of these children are under age 16. I am also speaking to you as the father of a nine-year-old daughter who has spina bifida and uses a wheelchair.

I must state that Bills 74 and 109 are very difficult to both read and understand, especially for the ordinary person. There is some ambiguity and there is the risk of misinterpretation by all parties involved. In discussing the acts with lawyers, they have found the same problems. In the short time allotted to me, I want to focus on the shortcomings of the two acts which will have enormous impact on the disabled children we represent and their families.

With regard to Bill 74, originally our major concern was to have included in the act children under 16, which would have allowed them and their families to benefit from the systemic advocacy promised by the act. As I had indicated, most parents are too exhausted from the stresses of looking after a child with a disability and do not have the expertise or time to embark on systemic advocacy to effect such changes. Furthermore, as our children were subject to the provisions of Bill 109, it seemed ludicrous to exclude them from what is supposed to be a companion act.

It appears that due to the amendment of section 3, the act now applies to children under 16 for the purpose of providing rights advice under Bill 109. However, my understanding is that they will have no direct representation or voice on the commission and certainly have no involvement



in the activities of the advisory committee in nominating representatives to the commission.

If the children are governed by the act as it relates to rights advice for the crucial purpose of consent to medical treatment, then surely we, their parents, are entitled to the same rights and privileges afforded other groups representing seniors and adults with disabilities. We must be afforded the right to represent our children on the advisory committee and the commission. To exclude us borders on discrimination.

Another major concern I want to bring to your attention is the rights of entry. As I understand it, if an advocate has a suspicion that, for example, my daughter needs his or her services, this individual can demand to have access to my home. If I refuse, I can be subjected to severe penalties. Let me assure this committee that any advocate would most assuredly be refused access to my home on the suspicion that my daughter needs his or her services, particularly as I have no say in regard to the selection, training or accountability of advocates as the act stands now.

Entry without a warrant seems to be an extraordinary power Canadian society does not condone. In this situation, the advocate would have more power than the police, because he or she can enter premises without a warrant. This is a dangerous precedent for any government to be setting.

If there is reasonable certainty that child abuse is going on in any premises, then obviously that child must be protected, but through legislation specifically designed for the purpose. However, the rights of parents, who are accountable for their children, must be respected, and in the absence of child abuse, a parent should be permitted to deal with his own or her private problems without undue interference.

Regarding Bill 109, our position has not changed. This act is very invasive and has the potential to create an unnecessary and destructive adversarial situation between the parent and child. The professional health care giver is also drawn into this unhappy scenario and will be frustrated in his or her sincere attempt to properly and quickly treat the child.

Parents of children with disabilities are used to working as partners with the health care givers: the doctors, surgeons, therapists, psychologists or any other specialist needed by their child. They are used to making decisions on required treatments, some of which have long-term benefits if administered at the appropriate time. Parents take on the responsibility of raising their child with total commitment, dedication, self-sacrifice and always with the best interests of the child at heart.

According to the act, if a health practitioner determines that a child 12 years of age or more is incapable, a rights adviser must be notified and the incapable child also notified of this finding. The criteria to be applied to determine capacity are not set out in the act, but are still unknown and left to be dealt with by regulations.

We know for certain that most children, whether deemed capable or not, would approach many medical procedures with considerable reluctance, even when they clearly understand that the treatment will benefit them. So

in the case of a mature, intelligent 12-year-old who refuses treatment out of fear, the act serves to create an adversarial situation between parent, child and health practitioner.

The act will interfere with the parent's right to provide the best medical care for their child, having gone through a lengthy process of medical consultation and soul-searching. The child may only be refusing treatment on an impulse out of fear and with little cognition of the facts and benefits of the treatment.

In an exceptional case where treatment may result in abuse or harm, intermediate investigative counselling should be available to parent and child. Should the potential for abuse through medical treatment exist, this would be more appropriately covered in legislation specifically designed to address child abuse.

Bill 109, as drafted, has the potential to delay treatment, causing harm to the health of the child, disrupting hospital schedules, severely damaging the parent-child relationship and placing an additional emotional and financial burden on families who are already carrying more than their fair share.

We cannot support Bill 74 as amended, particularly as parents and children are still excluded from the service they really need, which is systemic advocacy. We are also opposed to the rights-of-entry provisions because of the extraordinary power they provide to the advocate and the dangerous precedent they set.

We also cannot support Bill 109. The act needs to be clarified as to all the procedures to be implemented in its application. The vagaries and deferrals to regulations impede the possibility for open public scrutiny. What is clear is that the act contemplates adversarial procedures and has the potential to do more harm than good to children with disabilities and their families. We strongly object to the application of adversarial procedures to all children under 16 and certainly the very young, under-12 age group.

It interferes with the right of parents to decide on appropriate courses of treatment for their children in a demographic group that has more frequent need of medical treatment and technology than the rest of the general population. It removes decision-making from parents who know the medical and other needs of their child and places this in the hands of the government through a third party. This is a situation that parents of children with disabilities will not tolerate.

One factor that must be considered is the cost of implementing this act. We submit that the money would be better spent in providing an improved level of health service to children with disabilities. Therapy, technology and research can serve to improve the quality of life of many of these children and allow them the opportunity to play a greater role in society. Thank you.

**The Vice-Chair (Mr Mark Morrow):** Thank you very much. Questions or comments?

1450

**Mr Alvin Curling (Scarborough North):** I think your presentation brings to light some rather interesting questions. In your experience in the Easter Seal Society you of course have seen the handling of millions of children



over the years. The question I am going to ask is whether you see the rationale for the government to introduce Bill 74 because, as you say, the bill seems to be intrusive on family and does not seem to add the kind of support the family needs. Do you see any reason why the government would have introduced Bill 74?

**Mr Dawson:** I've only had time to look at it and discuss this in connection with children, and I see absolutely no value for the children. As I mentioned in my presentation, as parents we spend a lot of time with our children in and out of hospitals and treatment centres, taking them through their various therapies and other appointments they have to go to. We know what that child needs. We advocate for that child. What we really need is more therapy for the kids. We need more services for the children.

We don't need to have a third party intrude on a situation because of Bill 109. I'll just give you a little scenario. Somebody could be at a clinic with his or her 12-year old daughter and there's some serious surgery coming up. The child is reluctant to have the surgery. The parent says to the doctor, "Look, I'll take the child home. We're going to talk about this in the family, in a more peaceful environment," away from the hospital environment, which is always frightening. The doctor is then bound to intrude on that family's life and say, "Well, I have to notify the rights adviser that the child is reluctant to have this treatment." Two or three hours later this rights adviser could appear knocking at the door.

I think it's much better left to the parent and the child to talk about it, explain to the child why the surgery has to be done and deal with it the way we've been dealing with it all along. Common law is there. I see no value for children. It does not give us any benefit at all. It's very harmful. If Bill 109 weren't there, we wouldn't need Bill 74 from the children's perspective.

**Mr Curling:** Over the years, what sort of support would you say you got from the parents? Is it professional? I presume they understand their children's needs from a very informed base, because they work with their children. Would you say it's a high level of support, or average, or that a tremendous amount of support would be needed for advocacy? At one stage you said in here that many families or parents are very tired and overburdened by this and you said that they add a tremendous amount of support to the support you give here. Would you say their support is pretty high or average?

**Mr Dawson:** The family support is very high. What happens is that families tend to burn out. You can be at this level for a certain amount of time, but eventually the stresses of dealing with a child with a disability, of all the serious situations, the life-threatening situations that many families go through, will wear them out. But while they can, they do provide a tremendous amount of support and they do advocate.

We've had many families of children who've died who will come back into the system and they'll be there to support families. Yes, they're there because they know the need is there. They may burn out for a while but they come back again.

**Mr Curling:** My last question, do you think this bill itself will do more harm to that advocacy role the parents play?

**Mr Dawson:** I think it's not going to help it at all. It's going to do a lot of harm, because it's going to create more stress on the families and it's going to redirect their attention. A lot of them are not going to be able to go along with some of these stresses that are going to occur.

If it happens that a child is now going to go through a third party to decide whether he or she can have surgery, that's just going to put more of a stress on the family. They're not going to have the energy. It's going to be very harmful and it's going to create—particularly with teenagers; there are enough problems with teenagers, 13-, 14-, 15-, 16-year-olds. We don't need to add to those problems by giving them an out, a third party, that can possibly—there's no way.

It's going to just create a worse situation because, remember, the children are very often acting out of fear. Any one of us as an adult, confronted with the option of surgery, is going to think about it. I bet there are people in this room who've delayed surgery at times because they've been afraid; I would bet that. Children are going through the same emotions. It's definitely very harmful.

**Mr Malkowski:** Thank you for your presentation today. I would just like to ask for a clarification about subsection 34(1). I'd ask Mary Beth to clarify that section for us, please.

**Ms Mary Beth Valentine:** I would like to just clarify for the presenter that I'm not legal counsel, so this not a legal opinion you're getting officially, but I think it might be useful to try and clarify. Related to one of your concerns, that for rights of entry there could be an offence or a penalty, there is no penalty, no offence, for someone in a private dwelling. The issue of any possibility of an offence or penalty relates to facilities and controlled-access residences, definitely not to private facilities.

**Mr Dawson:** Okay, I thank you for that clarification, but—

**Mrs Sullivan:** On a point of order, Mr Chair: I wonder if you could further clarify that because it seems to me that even a private room of a patient in a controlled-access residence or a resident in a nursing home is in fact that person's home. I think that's the kind of situation where, if a child is in long-term care, which the presenter is concerned about, the access is in fact given without warrant by the act, perhaps against the wishes of the person involved.

**The Vice-Chair:** That's not a point of order, but if counsel wishes to clarify, she can.

**Ms Valentine:** I'm not counsel, but I'll try to clarify. You're absolutely correct, Mrs Sullivan, in your interpretation. As a matter of fact, the bill spells out that the access is to common parts of a controlled-access residence etc and that it is a different situation entering into an individual's apartment or room within such a facility. Then it would be the same type of situation as a private residence.

**Mr Dawson:** If I could just talk to that for a moment, we really have a real concern about that. I've interpreted



that to include private residences. I've talked to some lawyers who've also interpreted it that way. I feel that if this act is going to proceed, something should be put in there to exclude private residences, so that at no time could any family expect a knock at the door and not be subject to the—I believe it's a \$5,000 fine for an individual.

**Ms Valentine:** I think if you would read perhaps section 34, and then refer back to sections 17 and 18, where the descriptions are of "facilities," "controlled-access residences" and "premises," the clauses were specifically spelled out separately to indicate the difference for private residences.

**The Vice-Chair:** Thank you very much for that fine presentation.

#### RIGHT TO LIFE ASSOCIATION OF TORONTO AND AREA

**The Chair:** We have up next the Right to Life Association of Toronto and Area. Good afternoon. Just a reminder that you'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Mrs June Scandiffio:** My name is June Scandiffio. I am the president of the Right to Life Association of Toronto and Area. This is Gwen Landolt, who is our legal counsel.

I'd like to thank the committee for allowing us to appear once again. You have before you a very brief brief after all those many amendments. We'd like to indicate how pleased we are that there is a more precise definition of "vulnerable person" and that in fact the capacity to delegate someone as one's attorney was clarified as well. However, we have still a number of problems, and one of them we see as a new problem.

When we looked through the initial draft legislation before the amendments, there was never any indication to us or, I presume, to other people making presentations, that the age for consent for medical treatment would be dropped from 16 to 12. If in fact that had been the case, we would have addressed it in the original brief. It's something we're extremely concerned with. Certainly any child who is 12 years of age can be deemed capable of giving consent for medical treatment. As does the gentleman preceding us, we see it as fraught with many problems, one of the major ones being again this adversarial situation between parents, who are of course the prime care givers and probably know their offspring better than anyone else.

1500

One of the things, of course, is that a 12-year-old may very well understand the implications but, more often than not, young people are not future-oriented, and the idea of some treatment that is imminent having long-term effects for them might in fact be covered over. Their fear, as the gentleman mentioned as well, is going to make their decision be not necessarily an accurate one.

One of the things is that who is going to decide whether the child is capable is the health care practitioner.

Again, if the child is going to the doctor without the parents there, he may be giving just limited background, limited information. The doctor only knows what the patient, the young person, decides to tell him. One of the things we're extremely concerned with here is that there are certain provisions we see in the legislation proposed where a child at 12 and over couldn't make decisions, such as allowing transplant of certain organs of their bodies and so on.

One of the things we feel very strongly, if this legislation is going to go through, is that psychosurgery should be added to your list. A child who is mentally unstable, who is going to require treatment that is going to be potentially so dangerous and so long-term-effective, at a minimum, if you're going to go forward with this legislation, psychosurgery should be added to that list.

In addition, we have to wonder whether children who are experiencing drug or alcohol abuse, in addition to their tender years making it difficult for them to make a decision on treatment, are also handicapped by having an addiction. How clear is their thinking on accepting or rejecting treatment? I think these are areas that you're going to have to look into.

Of course, one of the areas that we see as a major problem is something like abortion on minor children without the knowledge or consent of their family. In addition to the aspects that I mentioned just generally for any treatment, to expect 12-year-olds to make a decision on something that is so important to them and to their future, not to speak of their pre-born child, is to ask perhaps far too much of 12-year-olds without the support of family.

I understand the reason this age drop perhaps was proposed was the fact that there was fear of reprisals on the part of the parents or guardian. If in fact this is the case, then I think, rather than dropping the age to 12, we should have facilities dealing with child abuse, where that child is not placed with that family. The child perhaps could be made a ward under children's aid or something to this effect.

But to just say carte blanche that every 12-year-old should be able to make health care decisions because there might be a problem with family is to us rather draconian. I think most parents in the province would be horrified to realize that they would be excluded from not only consent but even knowledge of their children undergoing or refusing treatment at these very tender years.

We have the Young Offenders Act, which of course is a whole different realm. The whole premise, I presume, for that is that young people don't always have the experience to make good decisions and that we're not going to punish them long-range for a bad decisions they made early in their life.

If in fact we're saying that sometimes immaturity causes people to make poor judgements, surely in something such as medical care, we can't say that the child all of a sudden has greater wisdom than we would allow for someone who does something wrong and then we allow them some kind of backup.

On page 5, I quote Dr Carol Cowell, who advocates in favour of abortion. In 1974 she said:



"I would caution physicians against accept *carte blanche* the 'self consent' of the adolescent girls 16 to 17 years of age for this abortion procedure.... I continue to be astounded at the lack of knowledge of this age group as to what is involved in a therapeutic abortion and its inherent risks....

"Paradoxically, when the age of minority was 18 years there were fewer problems than when it was reduced to 16 years. The depth of understanding and knowledge of the average 16-year-old is best described as 'impoverished' when compared with that of an 18-year-old.... At the time of an abortion, the younger teenager needs more than ever the support of her parent (or parents) because abortion is a very lonely experience...."

It would be interesting to see what she feels with the age being dropped even farther and farther back.

We have as well footnoted some other studies on the physiological effects of abortion, particularly on young women. I think the bottom line is, whether you are in favour of abortion or not, any parent in the province would be horrified at the thought that his or her 12-year-old would be either accepting or rejecting treatment on anything without his or her knowledge and consent.

I think the way it is set up in particular, as the gentleman referred to, where a third party can be brought into it rather than the family sitting down can cause more family breakdown and all kinds of other problems.

I would like, if I may, to move to page 11, just for a second, on living wills, a different area, Bill 108. We had indicated that when we were here before, we didn't see any reason for the legislation. I'll just go through very quickly some of our concerns that living wills can lead to misinterpretation. The documents are often vague or imprecise, and we certainly can't possibly put on paper every possible scenario for when we become incapable of making our own decisions.

The presumption here is that the family isn't to be trusted. I find it interesting that, really, do we have any evidence to say that parents or husbands or children of people who are incapable have in fact not been looking after their relative who isn't capable of making his or her own decision, or do we have cases where doctors have treated aggressively despite the objections of family?

I have not seen any indication that that's the case. If that were the case of course, then such a thing would be necessary. Sometimes the person may change his or her mind from when he or she executes the will to when it's going to come into effect.

My last point, although there are two other points in our brief, and my real concern was something that was reflected by Dr McMurtry years ago when similar legislation was being proposed in the late 1970s. Dr McMurtry was in charge of the Sunnybrook emergency section, and his question was this, "If in fact we pass such legislation"—as an emergency person, of course, he was used to making decisions rather quickly; we're not talking about long-term disability and so on—"do I, as a physician, when someone comes into the emergency, have to go through all their pockets to see whether or not they have a living will document?"

His concern was this: The flip side of treating or not treating is there, that if in fact they don't have certain provisos of when they don't want treatment, does that mean that legally he could be prosecuted if he doesn't do absolutely everything, whether or not he feels medically it's sound? He felt that it was questioning the competence of emergency room doctors to make the decision they thought was best for the patient and that they would be losing time looking for these documents and perhaps treating more aggressively because of fear of legal action taken against them by the family of the person if in fact he doesn't survive.

The bottom line is of course that every one of us has the right to refuse treatment. We haven't seen any reason why the common law has not been—it's been upheld, so why is this legislation being proposed?

I think most of the people who are concerned with this are the elderly or the people who have long-term disability. One of the alternatives of course would be to look after them, to make sure that their needs are being met so that they're not worried about being a burden or having a burdensome death.

If I may, I'll hand over for a minute to my colleague the section on page 9 of the brief on ensuring ordinary care.

1510

**Mrs Gwen Landolt:** We have some grave concerns that there is a monstrous loophole in this legislation. Section 46 says that personal care includes food and nutrition; that includes water and food. If a person empowers a power of attorney to look after him for personal care, it is quite conceivable that he can order under this, since he has the power, the removal of nutrition and in his view it may be in the person's best interests.

We don't for a moment suggest that it was ever intended that this would take place, that someone could simply be incompetent and lying in bed and someone figures that sooner than later to end his "suffering" he can withdraw ordinary care, which is food, nutrition and comfort.

What we would suggest and what we're very concerned about is that it should be clarified and a provision must be placed in the legislation that no one, even if the attorney may think it's in the best interests of the patient, should be deprived of ordinary comfort and care in keeping with his or her human dignity. We would like that clarified. That loophole is there, that the attorney for personal care could in fact say, "It's in the best interests of this patient."

Under section 14 the attorney is allowed to determine only according to the best interests, but in his opinion—and who's to say he didn't hold a valid opinion?—to withdraw ordinary care of nutrition and food may be in the best interests of that patient so as to end his suffering sooner than later. We would like to see that loophole covered, just to ensure that everyone, no matter what his or her capacity, is given the ordinary care of food, water and physical comfort regardless of what state of incapacity he or she is in. That's our concern.



Really we have three major concerns in this: one, to recapitulate, is that we are desperately concerned about removing and lowering the age of consent to 12; we are very concerned about the living will provision; and the third thing, to summarize, is that in this ordinary care there seems to be a major loophole.

We know what you're trying to do with this legislation is protect vulnerable people, but what in fact has happened is that it's overreached its objective. We would think that, before this is ever passed into law, there should be a very, very careful reconsideration. We are setting up a financial empire here of advocates. We're having intricate problems with the medical care that people need right away and we're showing that this will lead to a breakdown of the family unit, which, after all, is a very basic unit of society in this province.

We want mothers, fathers and children to work together, and in those exceptions when they don't, then you can have children's aid. Under the Child and Family Services Act, if there is a child in need of care—and that's what the act says—then the children's aid can step in, but the vast majority of people in this province do care about their children, they do care about their relatives who are vulnerable, whether parents, sisters or brothers, and this seems to be an overt intrusion into family life and the sanctity of family life and a breaking down of the family unit.

We do feel this will be extraordinarily dangerous and we would like to see this thing rethought entirely before it's passed into law, because the dangers are so powerful that I think there has not been the proper balance to protect all members of our society by this legislation.

**The Chair:** Thank you. Questions and comments.

**Mr Malkowski:** Thank you for your presentation. I'd like to clarify on page 2, the amendments, where you talk about concerns about complaints, an appeals process and the family's role. But in clause 7(1)(k.2) of our amendments of course we are subject to the approval of the Minister of Citizenship by making available to any person on request a written review process to deal with complaints from any person relating to the advocate. That's just to clarify that.

**Mrs Landolt:** Is that Bill 108 you're referring to?

**Mr Malkowski:** Bill 74, clause 7(1)(k.2).

**Mrs Landolt:** That gives the role, but there are internal controls of the advocates, that the commission is responsible for the work of the advocates. The problem we see is that a member of the public, a parent or a relative, doesn't have a way of appealing. That's our concern, that they're not getting the opportunity to have an appeal. The advocate may be acting according to his best interests and the commission may think it's to the best interests, but the family member does not have an outside way to appeal the decision of the advocate or to reject what they're doing. It seems to me it's the outside public appeal, as opposed to the internal controls of the commission, that we're concerned about.

**Mr White:** Just a small point with regard to the living wills: I understand your organization is basically very supportive of family rights, yet I would have thought the liv-

ing will is very much an enhancement both of the individual's and the family's rights within a very difficult situation where people have lost control of their lives and where aggressive medical technologies are being used to the disadvantage of their dignity, their sense of wellbeing. It will give them an opportunity, an empowerment, to state how they would like to have their lives ended.

**Mrs Scandiffio:** I think it's interesting right now. I know when my father and father-in-law were both very ill, the family had a great deal of input as to the treatment once our parents became incapable of expressing it. We were fortunate, in a sense, that it was a gradual deterioration, so we knew what their wishes were. They had an opportunity to express that to us.

To presume I cannot do that now without this legislation I think is a false assumption and to presume that doctors are always going to use aggressive treatment despite the family's objection—I would like to know if the OMA or the CMA have documented cases with families complaining, because that's not good medical practice if in fact the doctor isn't looking after my wishes or family wishes.

Our concern is that as soon as you try to put those wishes on paper, not every case scenario is going to be covered. In fact, with some of the elderly, there's the possibility of coercion, subtle or not so subtle; that they see I'm exhausted coming down to the hospital every night, that type of thing. It could be financial. Whereas in our province we're not going to be burdened with paying for the health care cost, in the United States it's a bigger problem. If my father saw that I'm going to lose my home because he's going to live another month and it's costing \$800 a day for the bed, he might be a little different in his attitude about treatment.

I see now the possibility of families working together. If either the doctor or the family feels the patient is being abused, I don't see that we can't rectify it now. There are ways for us to do that; we don't have to have a piece of paper.

My other concern, as I said, is the flip side of it, that if I don't have that piece of paper, does it mean therefore that I want aggressive treatment? I don't think that's necessarily true, but the doctor is going to say, "I don't see that."

**Mr White:** At present, though, the policies of hospitals differ in these areas. I know of many situations, some of which I'm very personally familiar with, where, frankly, people have been kept alive despite the expressed wishes of both the family and the individuals involved. As you say, that may fly in the face of some doctors' viewpoints; regardless, that is the kind of technology we're faced with at the moment.

**Mrs Scandiffio:** Well, I think to report those doctors—

**Mr White:** And having the opportunity to express one's intent empowers that individual and that family, I would think.

1520

**Mrs Landolt:** I would like to add something from a legal point of view. If a doctor is using excessive treatment contrary to the approval of the family, he therefore has



acted in a tort or wrongful act, because that's an assault on the patient. He is only allowed to act with consent, if the patient can give the consent and the next of kin gives the consent. So there's already set up under the common law that you can then sue the doctor as the next of kin, or the patient if he's able to, for tortious act of assault because he's given medical treatment without the consent of the patient or the family. That's a very serious thing. There's always the protection set in that they don't use excessive treatment because they have to get the consent always. If the family says no or the patient says no, they cannot do that because they'll be accused of assault. We have the 1990 decision of the Ontario Court of Appeal in Malette saying that the patient makes the decision or the next of kin, and the doctor has no right to contravene the decision, because it's an assault on the body.

**The Chair:** Mrs Scandiffio, Mrs Landolt, on behalf of this committee, I'd like to thank you for taking the time this afternoon and giving us your presentation.

#### AIDS ACTION NOW

**The Chair:** We're going to have a small change in the schedule again. I'd like to call AIDS Action Now as our next presenters. Just as a reminder, you'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the presenters. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Mr Alan Cornwall:** My name is Alan Cornwall. I'm a lawyer and I'm on the steering committee of AIDS Action Now. We appeared before your committee on March 24, I believe, made representations at that point and submitted to you a rather lengthy brief outlining our recommendations. I've brought with me today and delivered to the clerk a copy of a revised version of that brief. My presentation today will be quicker than the last. I simply propose to summarize a few of the major points we'd like to deal with.

Because I intend only to summarize a few of the important points outlined in our brief, I would ask the committee members if they would be so diligent as to perhaps read the remainder of our presentation and the recommendations contained in our revised brief of today's date.

I'd like to start by saying that AIDS Action Now endorses the recommendations and the submissions made by the Ontario Advocacy Coalition, which I believe made its presentation last Thursday. I'd like to now generally summarize some of the more important points in our brief.

First of all, as a general recommendation, we're recommending that the government make the amendments we have recommended in our brief as quickly as possible, enact into law these three bills and proclaim in force and implement as quickly as possible Bill 74, the Advocacy Act, as well as those provisions of part II of Bill 108 which recognize in law the ability of individuals to create legally valid powers of attorney for personal care.

This is something you won't find addressed in the advocacy coalition materials. In our last submissions to this

committee, we asked for all three of the bills to be enacted and proclaimed in force as quickly as possible. In fact, we endorse the delayed proclamation of the Consent to Treatment Act and the Substitute Decisions Act with the proviso that we would ask that the provisions in part II of Bill 108 which permit individuals to grant a power of attorney for personal care be enacted and proclaimed as quickly as possible, without delay.

The next point I'd like to address relates to the issue of the granting of powers of attorney in relation to procedures the primary purpose of which is research. I refer to section 15 of the Consent to Treatment Act and subsection 47(6) of the Substitute Decisions Act. In our previous submissions, we acknowledged that the Substitute Decisions Act contains subsection 47(6), which implied that a power of attorney which expressly so provides does confer authority for the attorney to consent to a procedure whose primary purpose is research.

As I stated in our earlier presentation, many people with AIDS and HIV rely upon procedures whose primary purpose is research to access experimental drugs and non-approved therapies. We believe all individuals should have the power to grant a power of attorney which confers authority to consent to such procedures. We believe all health practitioners must be required to recognize decisions made by validly appointed substitute decision-makers with respect to procedures whose primary purpose is research.

In the revised, amended versions of these statutes, subsection 47(6) has been removed from Bill 108 and section 15 has been amended to provide that nothing in the act affects the law as it relates to that issue. It's our humble representation that the common law on this point is not clear and we need clarification in the statute. If it's the intention of the committee to permit such powers of attorney to be effectively granted, then the act should be amended accordingly, because it certainly isn't clear at this point.

I've just learned recently that there is another government committee which will be addressing this issue in more specificity. We intend to make a presentation to that committee if that opportunity is available. We would like the opportunity to do that if this provision is not included in the Substitute Decisions Act and recognized in the Consent to Treatment Act.

The next issue I'd like to address relates to the revised Bill 109 provision contained in clause 5(2)(b), and that is the amended definition of "informed consent." In short, we believe this provision is unnecessary. It adds nothing useful to the doctrine of informed consent and should accordingly be removed from the proposed legislation. The "reasonable person" standard which is contained in clause 5(2)(a) of that act adequately protects a patient by requiring disclosure of relevant information sufficient to make a decision. The proposed clause 5(2)(b), which creates a more subjective type of standard, could potentially create a duty upon health practitioners to disclose irrelevant, personal or medical information to a patient where a reasonable person in the same circumstances would not require such information in order to make an informed decision.



Accordingly, we have recommended that subsection 5(2) of Bill 109 be deleted.

We do, however, recognize that this may have been an attempt to grant an added level of protection to persons and patients. In the event that it is this intention this committee wishes to address, if this provision is to remain in the statute we believe something must be added to make it clear that the right to information does not extend to personal and medical information relating specifically to the health provider but rather just to the actual procedure or treatment itself. In fact, we've recommended specifically that a provision be added to section 5 of Bill 109 stating that nothing in this act requires a health practitioner to provide personal or medical information about the health practitioner to a person.

1530

The next point we'd like to make relates to the definition of "treatment" contained in subsection 1(1) of Bill 109. As you're aware, the Progressive Conservative amendment that was requested in the last round was adopted and added to the end of subsection 1(1). I refer to the language "but does not include a prescribed thing." We strongly object to the inclusion of these words in the definition of "treatment" on the basis that the meaning of "prescribed thing" is unclear and could be used to severely limit a broad range of treatments for which informed consent ought to be obtained.

On the one hand, "prescribed thing" could mean anything prescribed by a physician. We would object to the exclusion of such treatments from the definition of "treatment" for the purposes of the Consent to Treatment Act. Alternatively, "prescribed thing" could mean anything prescribed by regulation made pursuant to the act.

If this is what is intended, it is our position that any prescribed treatments to which the act will not apply must be discussed before enactment of this statute and must be identified within the act itself and not by regulation. This issue must be resolved before enactment or proclamation of the act.

If this type of exclusion is to appear in the act, the following questions must be addressed in the act:

1. What treatments will be prescribed?
2. Who should determine what treatments are excluded from the act and how are they to be decided upon?
3. What criteria should be used to justify exclusion of a particular treatment?
4. On what basis should health practitioners be permitted to forgo the requirement to obtain informed consent?

Exclusion of particular treatments from the provisions of this statute would result in individuals being deprived of existing common law rights. The right to grant informed consent, which is embodied in this proposed legislation, must be viewed as fundamental and no person should be deprived of this right. Where, due to exceptional circumstances, the health practitioner wishes to proceed without informed consent, the circumstances in which such action would be acceptable should be clearly defined in the statute. The addition of the words, "but does not include a prescribed thing," is an unacceptable attempt to address

unidentified issues which can only be properly addressed by specific remedial provisions in the statute itself.

The process by which such exclusions are determined must be subject to the safeguards and public scrutiny of this process, the legislative process, and the process of the courts. At the very least, a set of criteria justifying exclusion of certain things or treatments or procedures from the definition of "treatment" must be set out in the act itself.

We're not sure what that amendment was intended to address. I note the questions that were asked of us at a previous presentation relating to diagnosis being included in the definition of "treatment." I'd like to reiterate the comments we made at that time in response to those questions. We believe generally, though, that it is not an appropriate mechanism for addressing any of those concerns to simply throw in a sloppy regulatory power. A power to make regulations does not address the issues that are being raised.

Finally, in closing, I'd like to just draw a general reference to our submissions relating to privacy and confidentiality of information. You'll find these contained on pages 11 and 12 of our brief. Specifically, we draw your attention to subsection 30(4) of Bill 74 and emphasize the importance of ensuring that certain types of medical information relating to individuals is highly confidential in nature and should not, in any circumstances, be open for disclosure by an advocate unless it's absolutely necessary for the health and safety of the individual.

We have proposed an amendment to subsection 30(4) of that act that was not adopted in the last round. We'd ask that you draw your attention to that proposed amendment again, as well as to our request that all records, files and information in the hands of the Advocacy Commission be made subject to the provisions of the Advocacy Act and not the Freedom of Information and Protection of Privacy Act.

In summary, those are the main points. Once again, I'd like to ask you to review the remainder of our recommendations. Thank you.

**Mrs Sullivan:** Thank you very much, Mr Cornwall. It might not surprise you that we go back to the comments you've made about treatment as defined in Bill 109. I saw Mr Sharpe here a few minutes ago. Has he left? I'm wondering if we could have both Mr Sharpe and Mr Fram at the table to address the point that Mr Cornwall has made with respect to the fact that in Bill 108 the definition of "personal care" does not include treatment, as included in Bill 109.

**The Chair:** Mr Fram or Mr Sharpe or both?

**Mrs Sullivan:** I think we need them both. The question that Mr Cornwall has raised is that in Bill 108 the definition of "personal care" does not include treatment, as defined in Bill 109. How will those two come together?

1540

**Mr Steve Fram:** The way Bill 108 deals with the issue is to talk about personal care and then a number of headings, the relevant being "with his or her health care." "Health care" is a broader term than "treatment" and it has to do with preventive measures, general exercise, all sorts



of things that include but extend beyond the issue of treatment.

When it comes to specific treatment issues, it's the consent to treatment issue that picks it up and says the first person to make a treatment decision, as defined under the Consent to Treatment Act, is the person named in the power of attorney as attorney. So that's how the two bills fit together.

Health care is a broader notion including treatment. The authority to make a treatment decision, in the consent context, is given by the Consent to Treatment Act. Isn't that the way we worked it out, Gilbert?

**Mr Gilbert Sharpe:** Is this on the record?

Interjection.

**Mr Sharpe:** The guardian is certainly empowered to make the substitute decision based on Bill 109, where health care treatment is determined. I think the simple, straightforward approach would be that if it's medical care of some kind, health care, 109 would govern and 109 recognizes the guardian as defined in 108, where the substitute consent provisions provide a role for the guardian. As you know, this is a gradation of family and people chosen by the incompetent person and so on, but the empowerment of the guardian comes through 109 and therefore it isn't necessary to look to 108 for the purpose of medical treatment or health care.

I'm sorry; I missed what the point of the question was in the context in which I'm giving this answer.

**Mrs Sullivan:** I think the concern of AIDS Action Now was that the power of attorney, which authorizes the attorney to provide consent for personal care, does not include the word "treatment", which is included in Bill 109, and the words "health care" are apparently vague enough that they may or may not cover the specifics of treatment as included in 109.

**Mr Sharpe:** The hope we had was that 109 would provide the notion of living wills and advance directives, and that through regulations and education people would come to think in terms of specificity when looking at termination-of-life decisions. These are Mr Sterling's bills that we were hoping to embrace in much of 109.

In the amendments to 109, when I was going through this a few months ago, I described how we had attempted to streamline the provisions so that more recent wishes expressed by the patient would govern where possible, and that while we would hope most patients who were concerned enough to complete a living will or an advance directive would take the time to follow the general guideline we would set out in regulations, they wouldn't have to use the forms we specified. We've met with groups like Dying with Dignity to make sure the flexibility was there.

While someone might just deal with 108 to set out a power of attorney with all kinds of instructions in it, our hope is that when dealing with health care and medical care choices, they would also be governed by 109, and that through our educational packages designed for the common, average person, they would have enough guidance to be able to do this, whether or not the provisions were embraced as part of the formal power of attorney that was

given under 108 or something much more simple designed just for treatment.

**Mr Owens:** Just in terms of your concerns around clause 5(2)(b), I'm trying to understand where that concern has come from. Do you have experience in the area that a person may claim to not have had informed consent if the care giver does not reveal personal details of his or her life?

**Mr Cornwall:** Our submission on that is not based on a specific experience or any number of them. It is, however, my understanding that, for instance, as an example, with the advent of HIV in our society there are many questions as to what types of information can be expected from a health care professional to be given to a patient. Just as an example, we believe it is inappropriate and unwarranted for a patient to make an informed consent argument around the HIV status of a physician.

While I don't think that type of request for information would be addressed or was what was intended to be addressed by this provision, I believe the addition of a subjective standard to section 5 in the definition of "informed consent" creates perhaps a duty on the physician to disclose that type of information. I don't believe that would be the intention of this section and I think that would need to be clarified if this was going to be included.

**Mr Owens:** Just a quick question to the ministry, and perhaps Mr Sterling, if he was here during the passage of the amendment, with respect to Mr Cornwall's concern about a prescribed thing. I'm at a loss to understand what that means, if someone from whichever ministry, Ministry of Health or someone, is available to explain that.

**The Chair:** That wasn't passed. That was just tabled.

**Mr Owens:** I see.

**The Chair:** There isn't anybody here to answer that at the moment.

**Mrs Sullivan:** Mr Sharpe is.

**The Chair:** Mr Sharpe? Oh, okay.

**Mr Sharpe:** Sorry, what was the question?

**Mr Owens:** In terms of the comment with respect to, "treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic—blah, blah, blah, down to the last sentence—"but does not include a prescribed thing," what does that mean?

**Mr Sharpe:** The concern that was raised by some of the groups that came to the first round of hearings was that the treatment definition was so broad it might include things like bathing a patient in a nursing home or matters that were not intended to trigger the rights advice and all the other protections that were here, that we might want to exclude from this comprehensive net we've established, because the approach we've attempted to take with treatment is of course a very broad one. It's that health care is something done by health care professionals, and with regulated health professions, that now includes a lot of people.

It might be that we decide to put in the regulations later on an exclusion or prescribe that the bathing of a patient in a nursing home would not trigger the rights advice and



other provisions of this bill. If the committee likes, I could come back with the list of things that had been raised as concerns by presenters in the spring and give you some of the examples we had in mind when we were preparing that.

**Mr Owens:** I think that would be reasonable, and perhaps once we get to the amendment stage we could take a look at some kind of clarifier as to what a prescribed thing is, whether it is prescribed by legislation or in terms of some of the activities you speak of at this point.

**Mr Sterling:** I was intrigued by your view that the Advocacy Act protects the privacy of an individual more than the Freedom of Information and Protection of Privacy Act. Why do you think that?

**Mr Cornwall:** That's a good question. I'm not sure I'm personally prepared to answer it today.

**Mr Sterling:** Okay, that's fine.

1550

**Mr Cornwall:** I believe there are safeguards in the bill that provide a greater standard of protection for personal and private information than does the protection of privacy act, but I can't give you specific examples right now.

**Mr Sterling:** Just as a matter of interest, I don't know whether we'd have to amend the freedom of information and privacy act as opposed to doing something else if we were to exclude this act from it. I see it as an added protection and not as something that would work to the detriment of privacy on the part of the patient. But you, yourself, perhaps didn't have the input on that part of the act.

**Mr Cornwall:** What I can tell you, though, is that the Freedom of Information and Protection of Privacy Act was not specifically designed for this type of situation. I think it would be wise for the committee to look very closely at the extent to which private and confidential medical information concerning an individual needs protection and the circumstances in which it's acceptable for that type of information to be disclosed and for what purposes.

I think this is an opportunity to look at the advocacy legislation, the Consent to Treatment Act and Substitute Decisions Act, and to assure ourselves that the degree of confidentiality, the degree of protection that's warranted in relation to highly sensitive personal medical information that can result in discrimination and severe problems if disclosed—to ensure that type of information is receiving the degree of protection that it needs to receive in this legislation.

**The Chair:** I believe we have some clarification here that you've invited.

**Ms Valentine:** Yes, the presenter is clearly correct: Through FOIPOP, it's possible for a third party to access information. In fact, after being raised earlier by your group and others, that issue was reviewed with the Information and Privacy Commissioner.

If you'd like to refer to Bill 110 at your leisure—page 8, section 11.1—Bill 110 actually amends section 67 of FOIPOP, which basically includes the Advocacy Act now

in the list of acts that are exempt from FOIPOP. It excludes specifically advocate client files.

**The Chair:** Mr Cornwall, on behalf of this committee I'd like to thank you for taking the time out this afternoon and giving us your presentation.

#### ONTARIO ASSOCIATION OF SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

**The Chair:** I'd like to call forward our next presenters, from the Ontario Association of Speech-Language Pathologists and Audiologists. Good afternoon. Just a reminder that you'll be allowed a half-hour for your presentation. The committee would appreciate it if you would keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Mr Rick Welland:** Good afternoon to you all. My name is Rick Welland. My colleague here is Sheila MacDonald, and we are both speech-language pathologists. As you will remember, we presented to this committee back in February, and we welcome the opportunity to return today.

As you know, speech-language pathologists and audiologists work with people who have communication disorders. Many individuals with a communication disorder do not have sufficient communication skills with which to speak up for themselves by making a presentation such as this or by lobbying their MPP. As the professionals most familiar with communication and its disorders, we are often called upon to advocate on their behalf. That is the role we will try to fulfil today.

In Ontario it's estimated that there are over 23,000 adults with communication disorders as a result of a stroke. In addition, each year more than 18,000 Ontario residents will sustain head injuries which can result in cognitive and communication difficulties. What these statistics do not include are the thousands of Ontario residents who have communication and cognitive impairments as a result of multiple sclerosis, cerebral palsy, Parkinson's disease, voice disorders, laryngotomy, dementia and many other causes.

**Mr Malkowski:** On a point of order, Mr Chair: I'm sorry, but the TV fuzziness is really distracting to me, watching the interpreter. Can we turn the background off on the TV? Thank you.

**Mr Welland:** I'll just pick up where I left off, if that's all right.

These individuals represent a sizeable proportion of the disabled population in Ontario, yet their unique needs and competencies are essentially unknown. They experience difficulties advocating for themselves, as I mentioned, in obtaining and comprehending information and in expressing and defending their rights.

A number of amendments to Bills 74, 108 and 109 have been proposed by the government, many of which were made in response to concerns raised by participants in the consultation process such as ourselves. OSLA strongly supports the majority of these amendments.



With respect to the Advocacy Act, we specifically welcome those proposed amendments that clarify how advocates will be regulated, include family members of vulnerable persons as well as professional and non-professional persons as potential members of advisory committees to the Advocacy Commission, clarify the responsibilities of advocates and provide for the existence of other advocacy services.

Amendments to the Substitute Decisions Act and to the Consent to Treatment Act that OSLA particularly welcomes include the requirement that two assessors, one of whom is not specifically a physician, conduct an assessment of capacity or incapacity, the creation of a registry for guardians and attorneys under a power of attorney for personal care and the involvement of family members in making treatment decisions for incapable persons, yet we continue to have concerns about the impact these acts will have on persons with communication disorders.

Concerning the brief that's in front of you at the moment, there really are only the first four pages I'll be addressing this afternoon. The rest are appendices.

If you can turn to page 3, one of our concerns that has not been addressed in the amendments is the definition of a vulnerable person in the Advocacy Act. OSLA continues to support the inclusion of communication and cognitive disabilities in the definition of a vulnerable person. Communication disorders are not adequately described by the terms "physical disability" or "mental disability." In only 40% of communication disorders is there a physical cause. Furthermore, few service providers who must interpret these acts will be familiar enough to know whether the root cause is indeed physical. For many communication disorders, there are multiple causes. In many cases no cause for the communication disorder is yet known.

1600

The term "physical disability" within the mind of the layperson and many health care professionals connotes an individual who is impaired in walking or movement. The term "physical" is misleading in that with most of the individuals with whom we're concerned it's not their physical limitations but rather their cognitive and communicative limitations that prevent them from exercising their rights. The term "physical" also overlooks the many communicatively impaired people who do not have physical impairments.

Furthermore, there's a concern that individuals with communication disorders in the absence of physical disorders would be mislabelled as "mentally incapable" on the basis of their inability to communicate adequately. For those individuals who are capable of conveying and/or receiving information, albeit in a modified form, and of drawing conclusions based upon this information, the assumption of mental disability would not be in their best interests.

For communicatively and cognitively impaired adults—and this is a quote from Rozovsky and Rozovsky—"one of the major problems affecting consent to treatment...seems to be rigid assumptions with respect to the ability to consent on the basis of the label 'mentally disabled' rather than on the actual characteristics of the individual concerned."

Mislabelling can have significant negative implications for individuals who have communication disorders. In fact, studies have shown that in the geriatric population being labelled "demented" often results in not receiving appropriate treatment in a timely manner and not having those needs and wants that can be expressed taken seriously. Unfortunately the label, once applied to an individual, remains, often being recited from one report to another without challenge.

It is for the above-stated reasons that we believe this section should read something of the form, "Vulnerable person means a person who, because of the severity of their mental, cognitive, communicative or physical disability, illness or infirmity, whether temporary or permanent, has difficulty expressing or acting on his or her wishes or in ascertaining his or her rights." We believe the inclusion of these terms, "communicative" and "cognitive," would serve to accomplish the following.

It would recognize in statute that communication and cognitive disorders or disabilities exist and that they are distinct from those that are usually connoted by the term "mental or physical disability." We believe that these populations have gone virtually unacknowledged for long. It would protect the rights of individuals with communication and cognitive disorders/disabilities, by so recognizing their distinctiveness; ensure that individuals with cognitive and communication disorders will not be denied access to advocacy services, and promote consistency between the different pieces of legislation already in existence. For example, in the Education Act communication impairment is recognized as a distinct type of exceptionality for students, separate from intellectual, emotional and physical impairments.

The second point: We believe that the rights of individuals who have communication impairments can only be ensured if there are directives within the legislation that indicate that they must be provided with appropriate assistance to comprehend the information and express choices to the best of their abilities. Appropriate assistance, we believe, requires that anyone who acts as an interpreter should be trained in the communication needs and techniques that are specific to that person. In some cases the interpreter may be a care giver who is adept at communicating using that person's methods, but in other cases it may be that a communication disorder specialist would be required who might act as an interpreter for that individual.

Such interpreter services should be required in any communication situation where the person's rights could be at risk. These situations would include assessments of capacity, explanations to the person about his or her rights, participation in decision-making, consultation with lawyers, communication with advocates and so on.

There is a further concern, which I'll add now. We wonder how the Regulated Health Professions Act fits in with the Consent to Treatment Act in section 1 where health professionals are defined. At the moment, even in the amendments, the Drugless Practitioners Act and professionals controlled by that act are mentioned specifically. So too is the Health Disciplines Act, but no mention is made of the Regulated Health Professions Act. We have a



concern that it be addressed in some fashion so the newly regulated professions will be included as health professionals under the Consent to Treatment Act.

I'm going to conclude now and turn the presentation over to Sheila MacDonald, who will present a brief videotape. In conclusion, I would like to say that in the final report of the select committee on Ontario in Confederation, published in February of this year, the Ontario government recognized the need to address the rights of those with communication disabilities.

There is a correction on the sheet you have. It should say "page 19" and, as I said earlier, communication disorders and intellectual impairments are specifically mentioned as separate categories of exceptionality in the Education Act. If these documents recognize communication disorders or disabilities as unique, surely these pieces of legislation can do no less. It is not possible for us to create equality for those with communication disorders in this province unless legislation provides direct guidance to Ontarians on what they must do when they encounter one who has a communication disability.

**Ms Sheila MacDonald:** Now I'd like to play two video segments for you that I hope will clarify some of the points and highlight some questions that have been addressed to us since our last presentation.

Those of you in the audience who might want to watch it may want to come around to the other side.

I'd like to play the first segment, which is that of a man who has no physical impairment and no mental impairment but does have a communication impairment. He has what we call aphasia, which means he has difficulty in understanding and speaking but he doesn't have, in the layperson's sense, any physical problems. He walks and does very well.

I'm hoping these two videos will highlight at least three points. First of all, the majority of people with communication disorders are not mentally, intellectually or even physically impaired in the layperson's sense of the term, and it will be many laypeople who will be interpreting these acts and acting on them. Second, each individual with communication and cognitive disabilities has a right to fair, objective assessment that will determine individual strengths and weaknesses, because these have to be looked at individually. Third, many communicatively disordered individuals feel they can make informed decisions if they have an interpreter; by interpreter, I mean someone who knows how to communicate with them. It doesn't need to be a professionally hired interpreter; it could be a care giver who knows how to communicate with them.

Here's the first person. Can you see all right?

[Video presentation]

1610

**Ms MacDonald:** In this case, this man has difficulty conveying his point. You can appreciate that he would require some interpretation in order to have his wishes clearly understood. The second point I want to make with this man is that he recognizes that there are some dangers in his trying to stipulate his own care or needs or wishes, that he could easily be misinterpreted. So he has insight;

he is a bright man who is having difficulty communicating.

Next, what I'd like to do is to show you a videotape that was made especially for this committee by the Aphasia Centre of North York. A group of people with aphasia, a communication disorder, got together and discussed their rights and they would like you to hear them. These are people with very mild impairment, so it's going to look as though you would understand them easily, but please appreciate that these disorders are on a continuum and that there can be more severely impaired people as well.

The other thing to notice when you're listening to this tape is how each person is different in the extent to which he or she would like to run his or her own affairs. I recognize the acts appreciate that, but we have to consider that each person may need different interpretation as well as respect for his or her individual rights.

[Video presentation]

1620

**Ms MacDonald:** What you just saw were people with different abilities who all are clumsy and slower in their communication. They're mildly impaired. There are many more severely impaired people. It's their communication that gets in the way. They are not mentally or physically impaired in any way and the terms "physical" or "mental" would not describe their difficulties.

The other point we've been making today too is that they do see a need for interpreter services to interpret to their lawyers, to interpret documents etc. Those interpreters don't always have to be professionals; in some cases it's a child they trust. But they should have a right to have that person present with them. Those who are working as advocates or lawyers or whatever should know that communication disorders exist in order to know that an interpreter may be required.

I have one more point to make, and that's in the conclusion here on page 4, that we have already in other pieces of legislation a commitment on the part of the Ontario government to consider communication disabilities. For example, on page 18 in the final report of the select committee on Ontario in Confederation, it says, "A particular aspect of such a review"—meaning reviewing barriers—"could be barriers encountered by deaf persons and persons with communications disabilities." I'd like to distinguish here that we're talking about communication disabilities, not communication differences such as English as a second language or not knowing the two official languages. We're talking only about those with communication disabilities.

I think it's not possible for us to create equality for those with communication disorders in this province unless legislation provides direct guidance to Ontarians on what they must do when they encounter someone with a communication disorder. It's not going to happen naturally. It doesn't happen naturally. For any of you faced with someone with a communication disorder, you would find it difficult and you would need to have an interpreter or someone there with you.



In closing, I'm going to use the words of those from the Aphasia Centre. This is a letter they drafted and it's attached to your brief:

"To whom it may concern:

"This letter reflects the feelings of a group of people with mild aphasia.

"We feel that we are able to do more things than many people give us credit for. It takes us longer but we get it done. Our problem is talking: We just don't have the wording.

"We believe that we should have the same rights as everybody else. For some things we may need a little assistance in the beginning, but we try to cope on our own.

"We are concerned for people who have a more severe form of aphasia. We had the same problems in the beginning: Other people made decisions for us. We couldn't defend ourselves, so we had to settle for what other people thought we wanted. Our families don't often understand us.

"Please have patience and protect our rights."

I ask you to consider our proposed recommendations.

**The Chair:** Thank you. Questions or comments.

**Mr Owens:** I spent last summer with the Ontario Association of Speech-Language Pathologists and Audiologists, and here we are one more time going at another piece of legislation.

**Ms MacDonald:** You can't get rid of us.

**Mr Owens:** I'd just like to state that I appreciate your comments with respect to those with communications disabilities. It's a concern I expressed last week with respect to persons who are non-verbal. It's my understanding from ministry staff that we're taking a hard look at how we go about assisting those without the benefit of verbal skills. Again, I appreciate your presentation.

**The Chair:** Ms MacDonald and Mr Welland, on behalf of this committee I'd like to thank you for taking the time out this afternoon and giving us your presentation.

**Mr Welland:** Thank you for your attention.

#### SUBCOMMITTEE REPORT

**The Chair:** We will now deal with the report of the subcommittee. Your subcommittee met on Monday, August 10, 1992, and agreed to the following:

"1. The committee shall hire outside legal counsel to provide the committee with a legal opinion with respect to the common law and the age of consent as it applies to children;

"2. The Chair of the committee shall write to the Speaker of the House to obtain written permission for the hiring of outside legal counsel;

"3. The Chair of the committee shall enter into a contract with legal counsel, not to exceed \$3,000;

"4. The committee shall have the Ministry of Health provide the committee with a legal opinion with respect to the common law and the age of consent as it applies to children."

**Mr Mark Morrow (Wentworth East):** Mr Chair, can we ask for a 10-minute adjournment, please?

**The Chair:** A 10-minute recess.

The committee recessed at 1626.

1631

**The Chair:** I call this committee back to order. There has been a slight oversight. We needed somebody to move adoption of this report first. Moved by Mr Sterling. Comments, questions? Seeing no questions or comments, all those in favour of the subcommittee report? Opposed?

Motion negatived.

**Mr Morrow:** I'm going to put a new motion on the floor for discussion. I think what we tried to do as a subcommittee was a very valid and very good idea. There's a lot of merit to it, obviously.

Interjections.

**Mr Morrow:** A lot of interruptions here, Mr Chair. I think it's everybody's realization that we're under an awful lot of financial restraints. We really should be looking at possibly doing it internally. I've talked to the Ministry of Health and it told me this isn't a problem. We do have the expertise here and I would like to move a motion that says that, Mr Chair.

**The Chair:** What exactly is your motion?

**Mr Morrow:** The original motion stating that we have an external legal counsel: Just change the "external" and move to "internal."

**The Chair:** Would it be easier to move number 4 from the original report?

**Mr Morrow:** Just give me one moment, please, Mr Chair. I'll just move item 4 of the original report.

**The Chair:** Mr Morrow moves that the committee shall have the Ministry of Health provide the committee with a legal opinion with respect to the common law and the age of consent as it applies to children.

Any discussion? Mrs Sullivan.

**Mrs Sullivan:** While I have great respect for the counsel in the Ministry of Health, the reason the opinion was asked for was that the counsel for the Ministry of Health presented, in amendment form, the age amendments as they've been put forward. It would not be my view that it would be appropriate for the Ministry of Health lawyers to provide us with this advice when in fact we're seeking alternate counsel to the opinions they've already put forward.

My understanding is that within government George Thomson has in the past, I think in relation to the Child and Family Services Act, done a similar internal study. It might be useful for us to obtain that.

I think the intention of the subcommittee was that counsel be available to the committee to provide advice that is independent of the Ministry of Health. The government member of the committee concurred with that in the subcommittee meeting, and it appears he's had advice and direction from outside the committee to the contrary. It seems to me unusual that he would have had that direction after the decision had been made. In fact, I think that's a bit of an affront.

**Mr Sterling:** I guess the reason I asked for some kind of clarification about the common law in dealing with



consent to health care treatment for adolescents in particular, but also children, resulted from a difference between what a very highly skilled physician came forward and expressed, his interpretation of the common law, and what we heard from a Ministry of Health official who differed with that particular physician.

Having practised law for some period of time before I was engaged in politics, I do know that lawyers differ from time to time and have differing opinions. It would therefore, in my opinion, be most helpful if we had someone other than the self-serving interests of the Ministry of Health state his opinion with regard to probably the most important issue in dealing with all these bills.

I want to say at this juncture that I am particularly peeved that during these hearings we've had sporadic attendance by the Health ministry's legal counsel. We've had no attendance by the parliamentary assistant to the Attorney General, no attendance by the Attorney General, no attendance by the parliamentary assistant to the Minister of Health, no attendance by the Minister of Health and no attendance by the Minister of Citizenship.

We are trying to be as reasonable as possible in reaching reasonable conclusions with regard to this legislation. To make the argument that \$3,000 is a large amount of money when we're considering the expenditure of somewhere between \$30 million and \$130 million—and we want to get it as right as possible—I think is a specious argument. Notwithstanding that, I would like to save \$3,000 if it can be.

What I suggest is that we get the Ministry of Health's legal opinion with regard to the common law on consent to treatment for children and then perhaps we might ask the clerk if she would take that opinion to outside counsel and ask them what it would cost to either confirm or differ from that particular legal opinion. If they confirm, we can then have some kind of costing as to what that might set the committee back.

I understand from the clerk that it's not possible until next week for this committee to expend any money with regard to an outside legal opinion. So we'll have time, I presume, to get the legal opinion from the Ministry of Health at that point in time and then we might ask the clerk to come back to the committee and tell us how much it's going to cost to either confirm or get another opinion if that is necessary.

1640

**The Chair:** Are you moving an amendment?

**Mr Sterling:** I don't know whether we need one if she's not going to spend any money at that point in time. If anybody disagrees with that, then I'll move an amendment to it.

**The Chair:** Okay. Mr Morrow.

**Mr Morrow:** Actually, I happen to concur and agree with both opposition parties. Mrs Sullivan raised a very good name, and I think it might help us out of this deadlock: George Thomson from the Attorney General's office. Would both be agreeable to that? Other than the Ministry of Health.

**Mrs Sullivan:** That's only part of the point.

**Ms Akande:** Is this an amendment?

**The Chair:** Not at the moment.

**Mr Morrow:** We don't have an amendment on the floor?

**The Chair:** Not yet.

**Mr Morrow:** So we're still dealing with my original motion.

**Mr White:** I'd like to concur with my colleague Mr Morrow. He's looked at an issue where, frankly, \$3,000 on as complex an issue as this is totally inadequate for outside legal counsel. For us to embark upon a project like this, it would probably be astronomical in cost. I think it's responsible on his part to look at internal resources.

I also concur with my colleague Mr Sterling that if the results of that consultation are inadequate, then perhaps we should look at outside consultation, because this is an important issue regardless. I'd like to put an amendment that we look at consultation from both the Ministry of Health and the Ministry of the Attorney General on this very significant issue. I think that goes along with Mr Morrow's point.

**The Chair:** You're moving an amendment?

**Mr White:** Yes.

**Mr Sterling:** Mr Chairman, with respect, all of the lawyers for the government, whether they're under the Ministry of Health or not, work for the Attorney General; they're all paid by the Attorney General. So you're not getting two different opinions from two different bodies; you're getting government lawyers giving you their opinion on government legislation, and that is the objection of dealing with that in isolation.

I don't suspect that the Ministry of Health's or the government's position with regard to the common law on this is going to be wrong. All I want is some confirmation from outside if somebody objects to it. I don't imagine it requires a great deal of research by those who deal in these matters on a day-to-day basis, and it probably would require very little time by lawyers outside who deal with this. There are five or six of them in the province that probably deal very much in this manner.

That's why I would say let's go through the first step of accepting 4, asking the Ministry of Health to provide that. We'll approve that, then perhaps once we get it there can be a motion, unless the government members find a great objection. It's not going to cost us, as I understand it, for Lisa to go to a lawyer and say: "Look, we've got this opinion. How much is it going to cost to either confirm or get another opinion?" All she's doing is finding out what the cost is for the committee. Do you want a motion for that?

**The Chair:** Mr White, would you withdraw your amendment for the moment?

**Mr White:** Certainly. I'm withdrawing on the understanding that legal counsel within any ministry may then be employed. Is that understanding correct, as Mr Sterling indicated?

**The Chair:** Yes.



**Ms Akande:** Well, I'm of the opinion that in either situation you've got lawyers interpreting case law, whether they're employed by the government or they're employed outside the government. If you're going to get changes in opinion, you're going to get them anywhere; if you're going to get similar opinions, you're going to get them anywhere. I don't think that whether or not they're employed by the government is going to make a difference.

Also, you've already responded to the question of our having this legal opinion and then looking at what it costs. So I think that at least we could have the first part of this motion passed and then perhaps deal with your part, which is the second, because as I understand it, Mr Sterling, you had not put forth an amendment. So if we could vote on Mr Morrow's question, may I call the question?

**The Chair:** All those in favour of calling the question? All those opposed? Carried.

All those in favour of Mr Morrow's motion?

**Mrs Sullivan:** I'd like a recorded vote.

The committee divided on Mr Morrow's motion, which was agreed to on the following vote:

**Ayes—6**

Akande, Carter, Malkowski, Morrow, Owens, White.

**Nays—2**

Curling, Sullivan.

**Mr Sterling:** Mr Chair, I want to move another motion.

**The Chair:** Mr Sterling moved that the clerk be instructed to take the legal opinion received from the Ministry of Health to outside counsel to determine the cost of confirming or providing an alternative opinion.

Any discussion on Mr Sterling's motion?

**Mr Owens:** Yes. What does it mean?

**Mr Curling:** Mr Chair, on a point of clarification: I'm trying to understand this. A motion was moved to get a lawyer within the system which wrote this bill to give an opinion on what they wrote. Do we have to move a motion for that? I thought we want an explanation of it. I understand Mr Sterling's motion to say that when questions are being raised here, of course the lawyers in all the ministries want to give their opinion—fine. But what he was saying, to my understanding, is that that would come automatically from the lawyers listening here to the questions being put by the members of the committee. What he's saying too, I understand, is that an outside lawyer, outside of that system, would give an opinion. We have a debate whether or not we could do that, so we're going to move a motion that the lawyers within the system give their opinion and then move the next motion that the one outside would give an opinion. I'm confused. Give me some direction on this. Do we have to move a motion all the time for this kind of thing?

**Mr Sterling:** Can I explain my motion? My motion merely says that once we get the Ministry of Health's opinion, we have instructed the clerk to go to an outside counsel to get for the committee a cost of either confirming or writing another opinion. Presumably that would not cost us one red cent.

**The Chair:** Any further discussion? Mr Morrow.

**Mr Morrow:** Mr Sterling, would you be agreeable to just getting an idea of a quote, having the clerk to that?

**Mrs Sullivan:** That's what the motion is.

**The Chair:** That's all he's asking.

**Mr Sterling:** I only thought that if the clerk had the other opinion in hand, the lawyer might say to her, "I entirely agree with this" or "I disagree with it." I don't know how long the opinion might be. If it's a page and a half or two and a half pages, it might take the lawyer all of five or 10 minutes. He'd say, "I agree with this opinion," and that would be the end of the case. That's why I thought it would be of some help if she had that opinion along with her. I don't know.

**Mr Morrow:** The only problem being, which lawyer would the clerk approach?

**Mr Sterling:** I would leave that to her discretion.

**The Chair:** The clerk has a list of experts.

**Mrs Sullivan:** I want to put it on the record now, before the vote, that I really object to this procedure. The government participated in the all-party steering committee decision to obtain counsel, and now, because minions from ministers' offices have come in and interfered with the decision of a government member who participated in that committee, a change has been made and all this cumbersome baloney we're going through is now occurring. I really object to that.

We have seen, as Mr Sterling has pointed out, inadequate attention paid by the ministers themselves to the entire affairs of this committee. In fact, it's my view that the ministers don't even know what's in their bills. Now we see representatives from the ministers' offices directing a member of this committee who is of the government party to change a decision and rescind the vote he took in the steering committee. I find that highly objectionable.

**Mr Morrow:** In all fairness, I had an afternoon to think about what happened there.

**Mrs Sullivan:** Baloney.

**Mr Morrow:** I reflected on it.

**Mrs Sullivan:** Baloney.

**Mr Morrow:** Excuse me, Mrs Sullivan. I allowed you to talk; now allow me to talk.

**The Chair:** Through the Chair, Mr Morrow.

**Mr Morrow:** I had the afternoon to think about the decision that was made and decided that it was not in the best interests to do that.

**Mrs Sullivan:** Baloney.

**Mr Malkowski:** On a point of privilege, Mr Chair: I think the language Mrs Sullivan is using is unparliamentary and should be withdrawn.

**Mrs Sullivan:** Mr Chairman, can I ask you to please get a ruling from the Speaker if the word "baloney" is now on the politically incorrect list of words that are not allowed to be used in this committee room or in the chamber?

**The Chair:** I don't believe "baloney" is on a banned list.

Further discussion on Mr Sterling's motion?

All those in favour of Mr Sterling's motion? Opposed?  
Carried.

Motion agreed to.

**The Chair:** Seeing no further business before this committee, we stand adjourned until 10 o'clock tomorrow morning.

The committee adjourned at 1653.









## CONTENTS

Monday 10 August 1992

<b>Advocacy Act, 1992, and companion legislation</b> . . . . .	J-123
Alzheimer Association of Ontario . . . . .	J-123
John Ellis, executive director	
Peter A. Singer . . . . .	J-127
Sparrow Lake Alliance . . . . .	J-132
Dr Paul D. Steinhauer, chair, steering committee; senior staff psychiatrist, Hospital for Sick Children	
Regional Geriatric Program of Metropolitan Toronto . . . . .	J-138
Dr Michael Gordon, geriatric specialist, Baycrest Centre for Geriatric Care	
Easter Seal Society . . . . .	J-142
Alan Dawson, parent-to-parent link coordinator	
Right to Life Association of Toronto and Area . . . . .	J-145
June Scandiffio, president	
Gwen Landolt, legal counsel	
AIDS Action Now . . . . .	J-148
Alan Cornwall, legal counsel; steering committee member	
Ontario Association of Speech-Language Pathologists and Audiologists . . . . .	J-151
Rick Welland, speech-language pathologist	
Sheila MacDonald, speech-language pathologist	
<b>Subcommittee report</b> . . . . .	J-154

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

- \* **Chair / Président:** Cooper, Mike (Kitchener-Wilmot ND)
- \* **Vice-Chair / Vice-Président:** Morrow, Mark (Wentworth East/-Est ND)
- \* Akande, Zanana L. (St Andrew-St Patrick ND)
- \* Carter, Jenny (Peterborough ND)
- Chiarelli, Robert (Ottawa West/-Ouest L)
- \* Curling, Alvin (Scarborough North/-Nord L)
- Harnick, Charles (Willowdale PC)
- Mahoney, Steven W. (Mississauga West/-Ouest L)
- \* Malkowski, Gary (York East/-Est ND)
- Runciman, Robert W. (Leeds-Grenville PC)
- Wessenger, Paul (Simcoe Centre ND)
- Winninger, David (London South/-Sud ND)

### Substitutions / Membres remplaçants:

- \* Cordiano, Joseph (Lawrence L) for Mr Mahoney
- \* Owens, Stephen (Scarborough Centre ND) for Mr Winninger
- \* Sterling, Norman W. (Carleton PC) for Mr Harnick
- \* Sullivan, Barbara (Halton Centre L) for Mr Chiarelli
- \* White, Drummond (Durham Centre ND) for Mr Wessenger
- \* Wilson, Jim (Simcoe West/-Ouest PC) for Mr Runciman
- \* In attendance / présents

### Also taking part / Autres participants et participantes:

- Auksi, Jutta, senior consultant, policy development branch, Ministry of Health
- Fram, Steve, counsel, policy development division, Ministry of the Attorney General
- Malkowski, Gary, parliamentary assistant to the Minister of Citizenship
- Sharpe, Gilbert, director, legal services branch, Ministry of Health
- Valentine, Mary Beth, senior policy and program adviser, Office of Disability Issues, Ministry of Citizenship

**Clerk / Greffière:** Freedman, Lisa

**Staff / Personnel:** Swift, Susan, research officer, Legislative Research Service



## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Tuesday 11 August 1992

**Standing committee on  
administration of justice**

Advocacy Act, 1992,  
and companion legislation

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Mardi 11 août 1992

**Comité permanent de  
l'administration de la justice**

Loi de 1992 sur l'intervention  
et les projets de loi  
qui l'accompagnent

Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
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## **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

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La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Tuesday 11 August 1992

The committee met at 1009 in committee room 1.

### ADVOCACY ACT, 1992, AND COMPANION LEGISLATION LOI DE 1992 SUR L'INTERVENTION ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervenants en faveur des personnes vulnérables; Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne; Bill 109, An Act respecting Consent to Treatment / Loi concernant le consentement au traitement; and Bill 110, An Act to amend certain Statutes of Ontario consequent upon the enactment of the Consent to Treatment Act, 1992 and the Substitute Decisions Act, 1992 / Loi modifiant certaines lois de l'Ontario par suite de l'adoption de la Loi de 1992 sur le consentement au traitement et de la Loi de 1992 sur la prise de décisions au nom d'autrui.

**The Chair (Mr Mike Cooper):** I would like to call this meeting of the standing committee on administration of justice to order. We'll be continuing the second round of public hearings on the amendments to the advocacy package. Before we start, Mr Wessenger would like to make a comment.

**Mr Paul Wessenger (Simcoe Centre):** Yes, thank you, Mr Chairman. I noticed, in looking at the Hansard yesterday, a comment by Mr Sterling that stated that during these hearings there has been no attendance by the parliamentary assistant to the Minister of Health. I'd like to put on the record, as I'm sure you'll confirm, that yesterday was the first day I'd missed being in attendance. The statement by Mr Sterling was completely inaccurate.

**Mr Jim Wilson (Simcoe West):** He can only correct his own record, Mr Chair.

**The Chair:** That's right. Thank you for that comment, though, Mr Wessenger.

### AD HOC COMMITTEE ON THE ADVOCACY ACT, SUBSTITUTE DECISIONS ACT AND CONSENT TO TREATMENT ACT

**The Chair:** I'd like to call forward our first presenters, the Ad Hoc Committee on the Advocacy Act, Substitute Decisions Act and Consent to Treatment Act. Good morning. As you know, you'll be allowed a half-hour for your presentation. The committee would appreciate it if you kept your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As

soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Ms Patty Simpson:** Good morning. My name is Patty Simpson. I am a registered nurse and policy analyst with the Registered Nurses' Association of Ontario.

My role today, however, is as spokesperson for the Ad Hoc Committee on the Advocacy Act, Substitute Decisions Act and Consent to Treatment Act, a committee made up of the Alzheimer Association of Ontario, the College of Nurses of Ontario, the College of Physicians and Surgeons of Ontario, the Ontario Friends of Schizophrenics, the Ontario Hospital Association, the Ontario Medical Association, the Ontario Nursing Home Association and the Registered Nurses' Association of Ontario.

The members of the committee reflect, as I think you will agree, a unique combination of family-based advocacy groups and health care, institutional, professional and regulatory bodies. All have a significant interest in the government's proposed legislation on advocacy, consent and substitute decision-making. Each has already made, or will be making, a submission on issues of specific relevance to its individual mandate.

The purpose of the joint submission distributed to you today is to highlight some of our major concerns about public safety and interest.

The committee acknowledges and welcomes many of the extensive amendments the government has already introduced. A number of substantive technical issues, however, continue to be of ongoing concern, and it is these which are the focus of much of the discussion and recommendations set out in our brief. We do not plan to go through these technical items with you today, except to flag them for your later review.

With respect to advocacy, the brief addresses issues relating to scope of the rights of access to records, rights of entry to private premises without a warrant and the definition of private premises, composition of the Advocacy Commission, means of dealing with complaints against advocates and terms of reference of the advisory committee.

With respect to the consent legislation, we have concerns about the reasonableness of using location of treatment rather than the nature of treatment to determine the need for rights advisers, treatment of patients in moderate pain when a rights adviser is not available within a reasonable length of time, the qualifications of and standards governing rights advisers, emergency admission to hospital in the event of an acute psychotic episode and the impact of the proposed legislation on the common law on restraint.

Finally, in relation to substitute decision-making, the brief focuses on the power of a guardian to apprehend, under a partial guardianship order, the impact of the powers of the Consent and Capacity Review Board on a Ulysses



will and assuring the reliability and validity of preferences or instructions—what is referred to as “wishes” in the bills.

These technical issues of content aside, the fundamental concern which has brought the members of the committee together is that implementation of these bills not place the safety and wellbeing of members of the public at risk.

It is this question of how the legislation is to be operationalized which constitutes the focus of our presentation today. More particularly, we have two goals: to convey to you the need for consultation in the development of the regulations and to convey the need for a comprehensive plan to ensure that clients, families and care givers understand their rights and obligations under the legislation before the legislation is put into operation.

First, turning to the issue of regulation development: The government has reiterated on a number of occasions that it does not intend the legislation to obstruct the effectiveness of day-to-day delivery of health care services, but it is precisely in the direct day-to-day delivery of health care that public safety is most at risk. Mechanisms and procedures that ensure that the operationalization of the legislation is both practical and consistent across a wide range of delivery settings are imperative. To a very large degree, however, these mechanisms and procedures will be matters of regulation, regulations which at this time are still totally unknown.

The extent to which the deliverers of health care services are to be involved in the development of such regulations has been quite unaddressed to date. We submit that a formal public consultation process for writing, reviewing and finalizing the regulations putting these bills into operations is required. In this regard, the requirement for prior publication and consultation of the proposed regulations under the Regulated Health Professions Act provides a very good model which we recommend be followed.

The second vital aspect of operationalizing the legislation is the need to minimize the risk to public safety by educating the public about what the legislation means for them as individuals. This set of advocacy, consent and substitute decision-making bills is arguably one of the most—if not the most—complex, interdependent and widely applicable packages of legislation to be introduced in the health care delivery system. Some or all aspects of the legislation will require application in a wide variety of health care sites: hospital emergency rooms, doctors' offices, long-term care facilities, community health centres, homes and schools, to name just a few. Furthermore, few members of the public will be unaffected by the legislation, whether it be as a health care client, a family member or a health care provider, be it a medical specialist or a health care aide providing personal care to an individual in the home.

The complexity of the legislation and resulting public perceptions and misperceptions about its meaning mean there is real danger that the system can become bogged down as individuals become unsure of or disagree about the technical requirements of the legislation. In this case, getting bogged down will not merely be a matter of efficiency; it will be a matter of individual pain, suffering and even life. Avoiding this means a paradigm shift in public

understanding about the legislation and the availability of the services promised by the legislation. Three conditions must be in place before the legislation is proclaimed if this paradigm shift is to work. These three conditions are:

1. The public must be educated about how they can express their health care instructions, what their authority is with respect to family members and what they are entitled to expect in terms of advice, information and assistance.

2. The infrastructures which will protect the rights provided by the legislation must be in place; that is, the Advocacy Commission must be established, sufficient numbers of advocates hired and trained, and the offices of the public guardian and trustee must be capable of handling the new demands on their services.

3. Health care providers, from heart surgeons advising on an operation to nurses in an emergency room to health care aides working in a nursing home, must be educated so that they can make the myriad of daily decisions about what is required to comply with both the legislation and their professional obligations.

None of these conditions will be possible without a comprehensive public education program, which in turn means time, money and planning. We recommend, therefore: (1) that proclamation of the legislation not occur until the necessary education programs have been initiated and the legislative infrastructures are not only in place but have also been tested; (2) that the government give assurances that sufficient funds will be available to conduct this education and to maintain those infrastructures; (3) that an implementation task force be established and funded by government to determine the core values, the common interpretation and preparation of materials to be used throughout the public and professional education program.

I would like to thank you for the opportunity to be here and to make this submission today. Both I and the other representatives of the committee who are with me today would be most pleased to answer any questions you may have.

1020

**Mrs Barbara Sullivan (Halton Centre):** I couldn't agree with you more on the point you've made about the necessity for prior publication of the regulations for public discussion so that they can be available, understandable and discussed in a manner that in fact makes them implementable. We've seen, as we've gone through this legislation, enormous difficulties that arise when words are understood in different ways or when, because of new rights being given, the best interests of the patient may in fact be interfered with.

Additionally, the setup of the implementation committee, as you've recommended, is one that I hope the government will take to heart. I think that whether it's advocates' groups, facilities that care for people who are ill or physicians' offices, the concerns that have been put before the committee about how these bills are in fact going to be put into practice are very serious indeed. I sincerely hope that the parliamentary assistant to the Minister of Health and the other representatives from the other ministries will take



those recommendations back to the ministers. We will certainly continue to emphasize them.

I'm interested in some of the material that's included in the attached paper, particularly with respect to the position of the advocates and new powers given to advocates that may well interfere with the facility providing health care or with the privacy of the patient himself or herself, that indeed may intrude on the patient's right to say no.

While your introduction has related more to the implementation, could you speak more specifically in response now to the recommendations made with respect to Bill 74: rights of entry and determination of vulnerability by the advocate rather than by the health professional?

**Ms Deborah Wall-Armstrong:** My name is Deborah Wall-Armstrong. I'm a board member with the Ontario Nursing Home Association. In regard to those issues, I wanted to point out what we're concerned with is an apparent lack of checks and balances in the advocacy legislation, which doesn't provide for the individual who may be deemed vulnerable by an advocate having an opportunity to challenge that. We are asking that consideration be given similar to that under the Mental Health Act in dealing with issues such as vulnerability and capacity and that the individual have an opportunity to be notified about that kind of decision and have an opportunity to challenge it if he has a concern in that regard.

In regard to the rights of entry, that's on page 11 of our paper. The main concern we have is that the advocates are being given powers to enter homes without a warrant. We find it very hard to understand why there's a need to be so excessive in this. The sanctity of private property is a cherished principle by all individuals. We feel this could create quite a bit of public furore. We frankly don't understand the need for it.

We've gone through the legislation and outlined where we see that the individual really does not have the opportunity to refuse an advocate entry without facing charges and fines. We really feel there isn't a need to go that far to properly implement this legislation. The existing powers available for the police if it is a true emergency situation should be sufficient for an advocate. Otherwise they should have to present information as to the need to enter an individual's private residence.

In my particular sector the concern is that we try to encourage involvement of family members with our residents. If I read this legislation correctly, if I take my mother-in-law home and she's vulnerable and because of her condition I open my house to an advocate having a right of entry at any time he wishes to have entry, I cannot stop that. I think a lot of people dislike that kind of idea. I have a concern about the facilities themselves in that the access, for example, into a nursing home may very well be a much broader access than even into a private residence. For example, an individual living in a nursing home—that is his home—would not have the right to stop an advocate from walking into his room whether he's in the middle of grooming, entertaining family or whatever. They're not given the same rights as an individual who is living in a private residence, in that in no part of the facility can you

stop an advocate from immediately entering without a request.

**Mrs Sullivan:** If I have an opportunity for a second question, I'd like to move to what I think is a very important aspect of Bill 109, the location of the treatment and the provisions of the amendments which provide different treatment of patients deemed incapable if it occurred, say, in a physician's office as opposed to an institution. You've noted that in your brief on page 19 and I wonder if you'd like to speak to that for the record.

Just while you're deciding who's going to speak to it, I think it's important that this matter be dealt with by the committee, particularly as we're moving from delivery of health care in large measure from the institutional sector into community-based sectors. This is a matter of some concern. Frankly, the amendments caught many of us by surprise and it seems that the government's intention is to slip them by.

**Ms Simpson:** There may be another member of our group who would like to speak to this, but I think that comments have highlighted exactly the issue, that is, that the location of the treatment should certainly be of lesser concern than the nature of the treatment that the patient or client requires. A lot of our intent in providing this submission to you today is to underscore our interest in quality-of-care issues and that is why we feel that to preserve the delivery of quality patient care services, it is essential to focus on the nature of the individual patient's care needs rather than the location in which that treatment or those needs will be met.

**Ms Barbara LeBlanc:** I'm Barb LeBlanc from the Ontario Medical Association. I suppose this would fall into the category of one of the practical implementation issues. I think the intention, as we saw it, of the amendment was a positive one, and that was to introduce some controls on when an advocate or rights advice must occur so that it did not in fact occur with every patient no matter how trivial the proposed treatment.

We consider the movement a positive one, but what it has done is that it's made a very difficult rubric of concerns. For example, the practitioner, depending on whether he or she is practising in his or her own office or in a facility, would have different considerations, would have to understand a different set of rules; depending on whether or not the patient was objecting, there would be different sets of rules and so on. I think our concern here is largely that the requirements are made understandable so that they will be implemented properly and that practitioners will in fact understand what's required of them and that rights advice will be made available to those for whom it should be made available.

**Mrs Sullivan:** Rather than simply the place where the treatment is proposed or where the determination of capacity is made.

**Ms LeBlanc:** Exactly. The other thing we've looked at is the whole notion of hinging whether or not rights advice occurs on whether the proposed treatment is a controlled act under the Regulated Health Professions Act. As I'm sure all of you know, there's been a long process over



about 10 years where there has been a consensus developed on what procedures and treatments are considered invasive or dangerous. So it seems reasonable to us to use that existing standard in this new legislation.

**Mr Jim Wilson:** Just to follow on that, would anyone like to comment on this question: Do you get the impression that your institutions are going to be stuck for the bill for these rights advisers?

1030

**Ms Wall-Armstrong:** From our association's standpoint, we have a long and very well-known history of difficulties with funding. There's a new funding formula coming forward for long-term care, but I'm not aware that this is being factored in yet. From our standpoint, obviously the government funds virtually all our costs, and we anticipate there will be cost in here and it needs to be taken into consideration. We hope the money would be allocated in addition to what they're already looking at in our budgets in long-term care reform. This would be an additional expense on top of what we already have.

**Mr Jim Wilson:** I just want to say too that we appreciate your comments, which were the focus of your oral remarks today, regarding the implementation and the phase-in of the various requirements in the acts.

Many of you and your members are members of professional colleges. Keeping that in mind, I was wondering if anyone would like to comment on the Advocacy Commission itself. The term "checks and balances" was used. I have a very real concern that we will have an Advocacy Commission that's at arm's length from government that has tremendous powers. It seems to me that the checks and balances we see in the provincial college system really aren't there and it's almost a double standard that the government has in this legislation versus the Regulated Health Professions Act. Are there any concerns you want to put on the record today regarding the commission?

**Mr John Ellis:** I'm John Ellis. If I can just backtrack one step, accountability is a very important issue that the group here is raising on a number of fronts, accountability of the rights adviser being one of them. Related to your last question regarding funding, the rights advisers really should be accountable to the Advocacy Commission itself. Funding is an important issue, but accountability is the overriding issue. Similarly, accountability of the Advocacy Commission, potentially a very powerful group, is fundamental as well. As the legislation currently reads, there really is no accountability for this group. There has to be some independent, arm's-length committee, panel or something which has the responsibility to oversee the work of the Advocacy Commission as well as to entertain complaints against it.

**Mr David Tilson (Dufferin-Peel):** I wonder if you could comment on the subject of the care giver, the parent of the handicapped child who—several from my riding have contacted me with the concern that all of these pieces of legislation are really going to mean more paperwork, more committee, more agency interference, when really all they want is to continue their health so they can look after their handicapped child, whether physically handicapped

or mentally handicapped. They're concerned that really all this legislation is going to do is to give them specific grief.

**Mrs Elsie Etchen:** I'm Elsie Etchen. I'm the president of the Ontario Friends of Schizophrenics. The families we represent have some degree of the problem you've put forward: the paperwork, the interference. They're very concerned about the complexity of the legislation. We've been having meetings, and people just cannot understand it. The worry is that there will be such an interference with the way you can access treatment for your handicapped child, or even a handicapped adult dependent upon the family for support, that the system will become almost a roadblock in the way to get access to treatment.

There are some improvements in the amendments so that access will be easier, but yes, you're right, the families are very concerned about the complexity, about the burden that's being placed on them to find their way through a system. It's a problem.

**Mr Tilson:** These same families, if I could continue, are concerned as well. Families who are looking after their children, their young people, are concerned about the bureaucracy and the unbelievable cost that this will have. Health is obviously out of control in the province; unbelievable costs.

They are concerned that from the other end of the scale, funding will be taken from other sources, such as long-term care, whether it be from care for the aged or—I can think of one specific parent who contacted me who was looking after their handicapped child and then expressed this concern about the items I asked in the first question.

They say at the same time that they're concerned about chronic hospitals being closed or the qualifications as to who's going to go into chronic hospitals, or that long-term care institutions are going to be closed for whatever reason because of shifting funding, and that their parents who normally would be placed in these institutions, because of a shifting of funding to cover these advocate armies and other groups—well, that's what they are; they're clearly advocate armies—it's going to cost the taxpayers of this province an unbelievable amount of money.

The fear is that other institutions will lose funding or will have to close, and that aged mother and father will have to return to these same families who are looking after their handicapped children or young people, by that time. I wonder if you could comment on that financial concern.

**Mrs Etchen:** With respect to the costs of the system, we hear from our families exactly what you hear, that the costs that are going to be engendered by putting this system in place could far better be spent on providing more services.

We all saw in the paper in the last few days the tragic death of Dominic Sabatino. The police just should not be called in circumstances like that. There should be crisis intervention services in the community so that crisis intervention services can be called on by families to go out and help them. These things are not available. These are the kinds of things that families want, more services rather



than some of the institutional superstructures being put in place here.

You're quite right. We are getting the same feedback as you are, that the costs are perhaps going to be taking away some of the services that people need, or money will be spent on the bureaucracy rather than on the service sector.

**Ms Zanana L. Akande (St Andrew-St Patrick):** Thank you very much for the brief. It's extremely informative. I'd like to ask a very general question. From the position in which your brief is written and from your comments in response to the questions you've been asked, I have the impression that you anticipate that every situation, every case—or many of them—will require the services of an advocate. Am I correct in that?

**Mrs Etchen:** No, I don't think we are expecting that every vulnerable person would have need for an advocate regularly.

**Ms Akande:** What types of—I'm sorry, I didn't mean to cut you off.

**Ms Simpson:** I was just going to add that our main concern is that the complexity of this legislation does not make it clear, certainly within the practice setting, to care givers when the services of an advocate or rights adviser are called for and when they are not. It's the operationalization of these three bills that poses very substantive concerns for the groups present here today.

**Ms Wall-Armstrong:** If I might add, in institutional settings, we anticipate in the nursing home, for example, there may be thousands of people who will need those advisers, certainly on an initial basis, in regard to care plans that are set up for elderly people on a regular basis in a setting. With the consent to treatment, initially we anticipate in our sector thousands of our residents having an immediate need for advocate services.

Over time, as the program comes into play, the demand will obviously lessen, but some of our people—and we're dealing with 30,000 residents in nursing homes alone, without other long-term care facilities—thousands of them will have, at day one, a need for those kinds of services. So we see it in our sector as a definite implementation concern.

1040

**Ms Akande:** What process is there in place now, when you say that thousands of those residents will require advocates right at day one? What process is in place now that allows you to deal with those particular—

**Ms Wall-Armstrong:** There is no specific process in place. All we have are care givers going on common practice and the public going on common practice. But once this legislation is passed, the care givers will be concerned that they cannot continue their past practices. Legislation is in place and they will be held liable if they continue to go ahead without putting those demands initially on the advocacy service.

It probably emphasizes even more dramatically the need for the educational process before the implementation. Many of the concerns the care givers have may be met, but that's why our whole focus today—our main, key

focus today—was about implementation, because we anticipate that without a good educational process it will almost nullify the effect as legislation. It will stagnate it right at the start, because there will be such a demand and people won't have an understanding. It won't be able to flow smoothly and it won't do the job it's intended to do.

**Ms Akande:** I agree with your last comment because I do believe, and we have intended, that those concerns are exaggerated. The advocacy legislation is really intended to address the needs of those who, as a last resort, require the assistance of a neutral body to come in and address their needs. We are not anticipating that every one of those people in your particular residences would require the services of an advocate. So your point around the education, addressing those concerns, is well taken.

**The Chair:** Ms Simpson, on behalf of this committee I'd like to thank you, as the spokesperson for your ad hoc committee, for coming out today and giving us your presentation.

**Ms Simpson:** You're very welcome.

#### YORK SUPPORT SERVICES NETWORK

**The Chair:** I would like to call forward our next presenters from the York Support Services Network. Good morning. A reminder that you will be allowed a half-hour for your presentation. The committee would appreciate it if you would keep your comments to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you are comfortable, please identify yourself for the record and then proceed.

**Ms Penny Hubbert:** My name is Penny Hubbert and I'm the president of the board for York Support Services Network.

**Ms Karen Hirstwood:** My name is Karen Hirstwood and I'm a program manager with York Support Services in the north part of York region.

**Ms Hubbert:** As our mission statement reflects, York Support Services Network believes in the dignity, individuality and independence of all persons.

York Support Services Network provides case management, social advocacy and community development services within the regional municipality of York. We have done this for the past 10 years. We serve adults who have serious psychiatric conditions, adults and children who have a developmental handicap and their respective families.

Services are offered through a variety of programs, including the adult protective service worker program and service coordination case management, for individuals residing in homes for special care programs through the triministry project.

York Support Services Network would like to reiterate our acknowledgement of this government's intentions to protect the rights of vulnerable people and applaud its efforts thus far. Our agency views this innovative legislation as a positive step.

Our comments throughout this submission are based on our experience in service delivery to the populations we have served for the past 10 years. Our remarks focus specifically on Bill 74 and Bill 108, and consideration has



been given to how these bills interconnect with Bill 109. These comments relate to the seven recommendations made in our presentation to this committee on February 19, 1992.

The proposed amendments to this legislation have addressed our concerns regarding training for advocates and issues of authority and liability. However, as we understand the amendments, the legislation falls short in some of the other areas addressed in our initial presentation. Our concerns address the following areas: public education, capacity to provide rights advocacy and case advocacy, community development, financial resources and the role of the public trustee's office.

In addition to specific concerns regarding these areas, we have a broader concern regarding the cost of implementation of the legislation. In our current climate of restraint, one cannot separate the potential cost of the legislation from the ideal or standard that it seeks to achieve. While we offer no specific recommendation, we do see implementation of this much needed legislation as an enormous task and pose the following questions: Should we review previous suggestions for service delivery of combining the proposed regional offices with existing services which have infrastructures in place? Could the phase-in implementation of this legislation be considered without the integrity of this legislation being lost?

York Support Services Network respectfully recommends:

1. That the public education function of the Advocacy Commission be strengthened and that Bills 108 and 109 include a public education component requirement;
2. That provisions are made for adequate human and financial resources to meet the level of need;
3. That the role of the commission in community development be further defined in operational terms and that the linkage with the broader service system be identified;
4. That the legislation make provision for emergency financial resources to provide a safe environment when all other options have been exhausted;
5. That Bill 108 make provision for restructuring of the office of the official guardian and trustee to ensure that response to issues is flexible and expedient.

The following comments will provide the rationale for each of the preceding recommendations.

**Public education:** Our previous recommendation: Given the complexity of the various bills which comprise the new legislation and their interconnection with existing legislation, a comprehensive public education campaign is required for vulnerable persons, their families, service providers and the community to become informed.

While the Advocacy Act has been amended to include public education as a function of the commission, there is no provision within the other bills which comprise the new legislation for public education. A comprehensive public education campaign is greatly needed by vulnerable persons and their families, service providers and the community if this progressive legislation is to achieve its goals.

It must be recognized that Bills 74, 108 and 109 do not create or extend new rights to vulnerable people, but rather

ensure that an individual's rights and preferences are protected.

We recommend that the public education function of the Advocacy Commission be strengthened and that Bills 108 and 109 include a public education component requirement.

**Capacity to provide rights advocacy and case advocacy:** Our previous recommendation: The commission needs to be aware that many rights-related issues in community settings can be very complex and that they require long-term involvement to reach resolution. This fact needs to be taken into account in the commission's determination of the advocate's responsibilities in case advocacy versus his role in rights advocacy, which in our understanding is short term.

The Advocacy Act clearly delineates between case advocacy and systemic advocacy. However, it does not address our concern regarding case advocacy versus a rights adviser.

#### 1050

As previously stated, our experience indicates that vulnerable persons whose rights have been violated or who have unmet needs often require longer-term involvement. This involvement is based on a trusting relationship which facilitates skill development enabling the individual to enhance his or her ability for self-representation.

The role of the advocate as described is essentially that of a rights adviser, which implies short-term involvement. Our concern is that the Advocacy Commission will not have the resources to meet the volume of cases or the time to remain involved in the situations which require longer-term involvement.

For example, during 1991 York Support Services Network provided active services for approximately 800 people. There are an additional 300 people on the wait list for service. Of these 800, approximately 560, or 70%, required advocacy services. These figures represent only one region of the province and two populations which comprise a very small portion of Ontario's vulnerable citizens.

In one situation, which is not unusual, it took over one year to identify the individual's issues and to complete the interventions necessary to resolve the issues. The identified issues centred on the need for alternative accommodation, access to financial assistance, a day program and some health-related concerns. All of these are issues which are frequently experienced by vulnerable persons.

We understand that the involvement of an advocate does not preclude the involvement of other support services where such services are available, but are aware that many of our most vulnerable persons do not have access to such services. It is our fear that without adequate resources, wait lists for advocacy services will develop and those individuals will face yet another barrier to receiving the support and assistance they need. We recommend that provisions are made for adequate human and financial resources to meet the level of need.

**Community development,** our previous recommendation: Given that the involvement of an advocate will potentially increase access to resources by vulnerable persons, that



there be ongoing commitment to the community development component of the legislation to address unmet needs.

The Advocacy Act assigns responsibility to the commission to ensure that community development strategies are applied in the provision of advocacy services. However, it falls short in addressing how this will potentially be operationalized. An additional consideration in this area is that of access, since vulnerable persons and their advocates will increase the demand for service. A system-wide commitment to the provision of resources, particularly financial, is essential or the work of an advocate will be redundant.

**Recommendation 3:** That the role of the commission in community development be further defined in operational terms and that the linkage with the broader service system be identified.

**Financial resources, previous recommendation:** Since the involvement of the advocate potentially creates a greater vulnerability for some individuals, that there be a commitment to the provision of financial resources to provide for an alternative safe environment when necessary.

The proposed amendments regarding non-instructed advocacy make provision for the advocate to provide advocacy services to a vulnerable person if the advocate has reasonable grounds to believe that there is a risk of serious harm to the health or safety of the vulnerable person. However, it falls short in defining what advocacy services include.

In many instances, a greater risk can be created for an individual when an advocate becomes involved and inadequate care or potential abuse is revealed. There is a need for readily available financial resources to provide for an alternative environment if necessary.

For example, recently on a Friday evening a York support services worker on her way to a social function noticed a client on the side of the road in a rural area. The client reported that he had left the residential home for special care where he had resided because an altercation had occurred between the client and someone visiting the home operator. The client had been struck by this person. The support worker was able to verify this information by speaking with other residents, and subsequently involved the police. The police were unable to find support for the client's allegations when other residents refused to speak with them. Therefore, their suggestion was for the individual to return home. The York support services worker contacted both another home in the area and a men's hostel in a nearby town. Both places had no vacancy. The client returned to the special care home.

The worker called the following morning and was informed that the client no longer wanted service. The worker then visited the client on Monday at his day program and found him to have two stitches in a cut on his cheek, which he reported to have occurred falling down stairs. This is just one example of the need for provision of financial resources for this type of emergency situation.

**Recommendation 4:** That the legislation make provision for emergency financial resources to provide a safe environment when all other options have been exhausted.

**Role of the public trustee office:** The previous recommendation was that the present structure and resources of the public trustee's office be restructured to ensure that the office can respond quickly to issues and with the flexibility outlined in Bill 108.

The proposed amendments address to some degree the concern regarding response to a need for emergency medical treatment and clearly indicate situations where a physician can act. However, they do not address the need to restructure the public guardian and trustee's office.

There are many instances where expedient action is required to ensure that an individual's rights are respected. This may involve access to funds or a situation where a substitute decision is required quickly. The current structure of the public trustee's office would not support this.

**Recommendation 5:** That Bill 108 make provision for restructuring of the public trustee's office to ensure that response to issues is flexible and expedient.

We would like to thank you for this opportunity to present our concerns. Karen Hirstwood and myself would be happy to answer any questions.

**The Chair:** Thank you very much. Mr Curling.

**Mr Alvin Curling (Scarborough North):** Thank you very much for your presentation. You've outlined, of course, the need for this direction in which the government is going, but you also warned about complexity and the extent to which it can go. You mentioned also that in order for it to work, there must be the financial resources and the proper training and education to along with it.

Just yesterday, there was a concern about finding \$3,000 to obtain another legal opinion on certain definitions in the bill; they were unable to come up with \$3,000 because they have to be very careful about expenditures within government.

Other presentations here have suggested that maybe they should have a pilot project first instead of going head-on with this, so wide and extensive and with the costs involved. You have warned that for all the good intentions of this bill, in order to include everyone somehow it may exclude some people in the process. Will you comment about whether they should look at a pilot project, especially in Bill 74; a pilot project for the advocacy instead of having it widely done over an entire province?

**Ms Hubbert:** Rather than a pilot project, I think they need to take a look at the people this involves, because it's obviously apparent that there are some people who are a lot more vulnerable than others. We're thinking particularly of people who are in homes for special care who are totally isolated and do not have any family members. I think it would be more suitable to take a look at those people who are in really vulnerable situations and implement this over a staged period, where maybe it doesn't start where it involves everybody initially, and maybe has to be phased in over a longer period of time.

1100

**Mr Curling:** You made a good point about those who may not have the family support. That should be looked at seriously. There's the other side of it too, that where the families have been involved this bill somehow excludes



the family and maybe brings more friction into the system. Do you see it that way too?

**Ms Hubbert:** I don't see it that way. I see that where families are supportive and contributing to the care and wellbeing of the person, this would build on that. It's really looking at those people who are either being abused by families or do not have anyone to assist them.

**Mr Jim Wilson:** I just want to begin by saying that if it was possible to love an inanimate object, I love this brief because I think you've spelled out in a very clear manner for all members of the committee some of the concerns you have and some of the shortfalls of this legislation.

On page 4 of the brief you have, I think, an astounding figure, because it really flies in the face of what the government's been telling us and what its public spin is with regard to the level of need for these advocacy services. The government's been telling us: "Don't worry about it. We're going to hire 150 or 250 advocates. We're not going to tell you the cost, by the way. The need really isn't that large out there, even though we're not quite sure what a vulnerable person is, but we're pretty sure that the need won't be overwhelming and that the commission will be able to handle it," that sort of thing.

But your figure here says that of the 800 clients you were able to get to in 1991, 70% required advocacy services, and you had a tremendous waiting list after that. Could you describe for me what your definition of advocacy services is, because I will again say that your comments throughout the brief match what we've heard from many other groups, that they're doing the advocacy but where the real problem comes is that there aren't the resources to help people. In fact, later in the brief you make an astounding observation. You bring to our attention that advocates could make matters worse, because problems are discovered but the financial resources and community resources aren't there to help people. Would you comment on all that, please?

**Ms Hubbert:** First of all, there are a couple of things here. If we're looking at short-term numbers and people needing assistance in the short term, that's one thing. Part of the network's service is that we build on what the individual has. We don't see that these individuals should be dependent on us for ever. A lot of our time and focus goes into the retraining and skills training the families and the individual need so they can advocate on their own behalf.

In fact, we do have an advocacy guideline we use, and the first level of that advocacy guideline is that we only provide what is necessary. Sometimes that's just information for families or for clients and they advocate on their own behalf once they have that information. Where they can't, then we advocate with them, if that's possible, and in some cases we advocate for them where they're unable to do that. We also take a look at systemic advocacy: Is this a service delivery issue and can we assist in getting that corrected?

If we're going to be committed to this, committed to the integration of all populations into society, then we have to look at providing them with the education they need so that they are not completely dependent. I think what we're

seeing is a result of a way of providing service in the past that has made people very dependent so they're not able to do this for them now; hopefully, that would improve in the future. The other issue is that this takes time. This is not short term. You have to work where the person is and build on that.

As to your comment about the fact that many people do advocacy in the community and that bringing in another advocate may complicate that issue, I would certainly agree. Sometimes it takes a year to develop a good relationship with people and to actually get them comfortable enough that they can express to you what their concerns are and where they feel vulnerable, particularly if they're living in a home for special care, say.

It would be very difficult to delineate and say, "Hold it; now is the time for the advocate to come in," because the advocacy starts really from day one in your relationship with the person.

There have been situations in another field that I'm involved with where social workers do a lot of the advocacy with the person. When it becomes a legal issue, they consult with the Advocacy Centre for the Elderly and they get the information and they take that back to the client again so that the client decides when they need it or if they feel they want to involve advocacy at that level.

So that's one thing that we have had difficulty with: When would this advocate be called in? Does this mean that our front-line staff at some point would have to say, "I've gone as far as I've gone; we have to call in someone else"? It would hinder the process.

**Mr Jim Wilson:** Thank you very much for your comments. I have a question for whichever parliamentary assistant would like to answer. I'd like to know the cost of implementing this legislation, where the money's coming from, if money has already been set aside in budgets, because we went through the estimates process this year, the cost to the commission, the cost of hiring the advocates. We've asked this several times, and I don't think we've ever gotten a satisfactory answer. The government's had several months to think about this, and it's really quite unbelievable that it wouldn't have a figure at this point.

**Mr Drummond White (Durham Centre):** It wouldn't stop people from hypothesizing.

**Mr Jim Wilson:** Yes, it would stop people from hypothesizing if you people would come forward and tell us the cost of this bloody thing.

**Mrs Sullivan:** And how much money's committed.

**Mr Jim Wilson:** And who's going to get cut so you can transfer money to this new system.

**Mr Gary Malkowski (York East):** Thank you for the question. Right now we're here to hear from the witnesses today on the amendment level, but we do have costs, and there's an analysis in the study going on right now. The report is not yet completed.

**Mr Jim Wilson:** Perhaps Mr Malkowski could give us an indication of when that report will be completed.



**Mr Malkowski:** Okay. The costs so far that we've got, after the advocacy system has been established, will be roughly \$23 million.

**Mr Jim Wilson:** That's ongoing, year-to-year operating cost? What's the cost of getting the system up and going? Mr Chairman, it'd be more helpful if the parliamentary assistant would undertake to provide the committee with a breakdown of the costs of getting the system up and going, the timetable involved, how many advocates they envision hiring, training costs—just a complete breakdown of that \$23-million figure.

**Mrs Sullivan:** If the rights advisers are included.

**Mr Jim Wilson:** Mrs Sullivan's just made an excellent point. We'd also like to know whether the training and salaries of the rights advisers are included in that figure.

**The Chair:** If Mr Malkowski could provide the committee with that information.

**Mr Malkowski:** We'll check the information and get back to you, okay?

**Mr Jim Wilson:** But, Mr Malkowski, you did say there's an ongoing study. When will that be tabled? When will it be ready? I still need an answer to that question, if you don't mind.

**Mr Malkowski:** First we're going to have the implementation, and the ongoing study is what's going on.

**Mr Tilson:** I have a couple of questions as a result of that information. The information that's been given by Mr Malkowski pretty well answers the questions I have that the government really has no idea where it's going on this issue financially. I look at the many calls that come into my constituency office, whether it's workers' compensation, which is a bureaucracy that's completely out of control—I mean, you call up and they don't have the bodies to answer the phone, let alone deal with problems—or whether it's social services or any matter that's involved with government; you set up these wonderful bureaucracies, and this is going to be the mother of all bureaucracies. It's going to be an unbelievable bureaucracy. I don't suspect that the figures that have been suggested here even come close.

1110

I look at your recommendations and I understand them. They're very admirable. But the cost of this—is the government way over its head? Are they going to get us into something where we're going to create something and people are going to call up my office and say, "You, as the MPP—I call up this advocate army and they don't have enough members of the army to go around and help us"? Is it something that's completely—is it a dream? Is it out of control? Or is it something that a government can realistically put forward?

**Ms Hubbert:** I personally think the government's been way over its head for many years. I think this is not a recent thing that has developed. I think the long-term care initiative is one of the first initiatives looking at how they can take a system with some very good services available and provide them in a cost-effective way by amalgamating some of those services and taking a look at how it's done.

I'm not convinced, personally, that with the advocacy a whole new system has to be developed. I think we really have to take a look at what exists and how we can build on what exists, and that we can't provide the Cadillac at the beginning. After listening to seniors and people with physical disabilities over the last three months in York and Simcoe during our long-term care consultation, I was quite surprised to find that taxpayers are not looking for a Cadillac service. They understand that it's their taxpayers' dollars that are paying for this. What they want to know is: "What is the plan going to be? Is my relative not going to get service until 1996, when that specific service is going to be in? Fine. Just let me know, and let me know that there's been a fair ground for things to be planned out and that there is an overall plan."

I really feel that consumers are very realistic when it comes to the cost of services, and do not expect everything at once.

**Mr Tilson:** When I look at your recommendations, a lot of which are financial, you're asking for confirmation of financial resources, or that provisions be made. I'm looking specifically at your recommendation 2. Is the government capable of providing that? With this system that's being created, is the government capable of providing not only the financial but the human—we have to train all these people. Getting along with the question over here, it will be interesting to see. That's a whole other bureaucracy, the bureaucracy of training all these people and keeping them retrained. It's going to be an unbelievable expense. Is the government capable of dealing with your recommendation 2?

**Ms Hubbert:** If you take a look at building on what exists, on using the resources that are out there and on limiting who we initially start to provide these services to, yes, I think they could. The whole population that we deal with are vulnerable individuals, and they have been at the bottom of the heap for a long time. No one speaks up for psychiatric individuals in the community or for those people who are developmentally delayed.

We could do this with our case situation. We could identify those who are the highest priority of need. When we as an agency talk about having emergency funding, we're not saying that every client we have would get into this situation where we would need emergency funding. This is not an everyday occurrence, but we really feel that when we have a situation where someone is going to be put at more risk because an advocate or someone has been involved, we have to have the \$35 or whatever it is to get that person out of there that night until we can find another system.

The other thing is that I don't think you can do this isolated. We have a system where in the whole of York region we could not find an emergency bed for someone who was at risk, so it's not just a matter of dollars for advocacy; it's also a matter of building on the services that exist and how we can provide that service. How can we expand a service that exists already so that they would have an emergency bed?



**Mr Tilson:** The fear from the general public that has been expressed to me is that when you set up a system such as this, whatever government service is being provided, eventually it gets so big that the service becomes slow. I'm following along your area of the emergency services. So for emergency services required, you need an advocate or you need something that is provided under this bill, but because it gets so massive—and it will become massive—will that create more problems? In other words, the slowness; it's not something new I'm telling you. No matter what agency, because of lack of funding or lack of human resources, government moves slowly. If the law says, "Thou shalt have an advocate to do something," and the other group of people can't move without an advocate, then is the whole thing scuttled? Have you solved one problem but created 10 other problems?

**Ms Hubbert:** When the Honourable Ms Ziemba presented at our spring conference last year, she assured us at that time this would not mean that people who are out there now doing advocacy would not continue to do what they already do. In the example situation that we gave, if there had been an emergency bed an advocate would not even have been involved; this would have been something our agency would have done.

**Mr Tilson:** But they will now, and there are going to be major problems.

**Ms Akande:** I'm very interested in your report. I really can't say anything but positive things about the services that advocates provide. I think you would concede that in many ways all of us are advocates, all of us who work with or live next to or are involved somehow with vulnerable people. Whether intentionally or not, we do become informal advocates. It would be our expectation, our hope, that this type of advocacy would continue.

I've asked this question before. An official advocate, an advocate who exists or operates at arm's length, the kind of advocate that O'Sullivan's report emphasized that people outside were requesting and asking for: At what point do you think that type of advocate would be necessary? Use the scenario of the case that you were just using as an example.

**Ms Hirstwood:** The answer to that question is difficult because it's different for each person. It depends on the individual's level of skill. The example we used was of someone who is quite vulnerable, who lives in either a residential home for special care or a boarding home situation and has no one to support him. They have no informal advocates in most cases because those homes aren't viewed as being the most positive settings by the community around them generally. So they rarely have someone to support them in any other way.

In those kinds of situations, you would need an advocate quite regularly. As a matter of fact, in that situation you would need one right away, because I'm not allowed on the property. As a person providing service, I'm not allowed on the property of that home operator. I have to arrange to meet the client beyond. When I call to set up a meeting, they'll report that the client doesn't want service. However, when I see him at the day program, he is very

desperate for service. He really wants some help; he wants to move. But there are limited resources, so there aren't a lot of choices for him to move to.

**Ms Akande:** So that situation itself identifies the need for the kind of advocacy legislation that we have in place or that we're talking about now.

**Ms Hirstwood:** Exactly.

**The Chair:** Ms Hubbert, Ms Hirstwood, on behalf of this committee, I would like to thank you for taking the time out this morning to give us your presentation.

1120

#### ONTARIO FRIENDS OF SCHIZOPHRENICS

**The Chair:** I'd like to call forward our next presenters, from the Ontario Friends of Schizophrenics. I'll remind you that you'll be allowed a half-hour for your presentation. The committee would appreciate it if you would keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, would you please identify yourself for the record and then proceed.

**Mrs Etchen:** My name is Elsie Etchen and I'm the president of the Ontario Friends of Schizophrenics. With me is June Beeby, who is the executive director of OFOS.

OFOS is an organization of approximately 3,000 family members who have direct knowledge of schizophrenia in caring for a family member who suffers from this disease. Many other families with persons with schizophrenia contact our provincial office and local chapters daily.

Schizophrenia is the most prevalent of all psychiatric illnesses and is also one of the most costly. Everyone has a 1% chance of developing schizophrenia, and at this time there are approximately 50,000 people with schizophrenia in Ontario.

Schizophrenia can be treated with anti-psychotic medications, but the common experience we have in OFOS is that many of our family members resist taking medication and avoid going to the hospital because their judgement is distorted and they have little insight into their illnesses.

During the hearings in February and March, a number of family members shared their difficulties in trying to get care for a severely ill schizophrenic relative, and I'm sure you remember their passion and concern. We can't possibly duplicate that here, but they don't want to be pushed aside by another system. They want to be recognized as advocates. They don't want to be steamrolled by a bureaucracy. Often, their efforts have been frustrated because of the restrictions in obtaining care, and these restrictions arise in the Mental Health Act.

We've already discussed earlier today the problem of services. You all saw the tragic headlines about Dominic Sabatino. We're very concerned that the costs of this program not take away from the services. We're also very concerned that crisis intervention services be available to people like that in a community.

In our March brief, we endorsed the principles on which the bills are based, but while we endorsed the principles we found the bills lacking because they did not



provide the balance between protecting legal rights and providing speedy access to treatment.

In Bill 74, rights are emphasized and needs and wellbeing are not.

On May 15, 1991, Premier Bob Rae answered our request that families be recognized as advocates for their relatives with schizophrenia by saying, and this is a direct quote from the letter he sent to us: "Your plea for more involvement in the mental health care decision-making process is indeed needed. The full partnership of consumer, family, service providers and medical practitioners is a necessity."

Bill 74 was not written, and has not been amended, to make Premier Rae's suggested partnership a possibility. Among the most important changes that we seek in Bill 74 are: mandatory participation of families in the Advocacy Commission and the appointments advisory committee, if there is to be one; a specified role for the mandatory advisory committee in the legislation itself; a publicly accountable Advocacy Commission; an improved complaints procedure; a definition of capacity to instruct an advocate, and above all, recognition that needs and wellbeing are as important as protecting rights.

I also want to remind you that the provisions relating to access to private homes by advocates remain in the amended bill. The bill gives more access to a private home for an advocate than is presently the case for a police officer. We are asking you to protect the privacy of families in their own homes. There are still ways to protect vulnerable persons, and we've put forward recommendations to take care of this.

With respect to Bill 108, we would say again that some people with schizophrenia agree to be treated, while some people refuse treatment.

We are very pleased indeed to see that our recommendations concerning living wills have been incorporated in this bill as an expedited power of attorney. We propose two principal changes to make it more useful to our families. First, the test of capacity to make such a power should be something less than "capable of personal care." We propose a test requiring the grantor to be able to understand what he's doing.

In the second recommendation, section 50 of the bill, establishing the expedited power of attorney, is somewhat ambiguous in relation to detention. An attorney with a validated power can use the necessary force to take the incapable person to any place for care and treatment, but there is no provision for detaining the person so that he or she may be treated in that place.

The low standard of capacity in the new subsection 47(1) also causes us concern. One characteristic of schizophrenia is that persons with this disease are often able to understand information but are unable to apply it to themselves. We are concerned that persons with schizophrenia, when they grant a power of attorney, may not be able to judge whether the person is capable of exercising that power of attorney.

We are also concerned that there is a higher standard for giving instructions than there is for revoking a power of attorney, and this would seem to allow an incapable person to revoke instructions he made when he was capa-

ble. We've explained what schizophrenia is, episodic, so this is a real problem for us: the capability, incapability, capability again, so we propose amendments to the low standard of capacity.

Our great disappointment in this bill is that there are no substantive amendments to the guardianship provisions in sections 52 to 62, and we submitted a paper, *Will Guardianship Work for Persons Severely Ill with Schizophrenia?: A Case Study*. The approach set out in Bill 108 is not feasible for relatives, yet guardianship may be the only alternative available to families whose incapable relative refuses treatment. Court processes are slow, legal costs significant, and delays in treating a severely ill person almost inevitable and they can lead to disaster, as the newspapers demonstrate.

An expedited form of guardianship seems imperative to our family members in order to prevent serious adverse affects. We believe we understand the temporary guardianship clauses in the bill, and we find that they are not the answer. Families must be involved in addition to the public guardian and trustee and the courts.

The register established in section 75(1) we regard as absolutely essential, but the access provisions in it are a flagrant invasion of privacy of vulnerable people, and these must be tightened up.

In Bill 109: As you heard this morning, we've been a member of the ad hoc group, and we proposed some of the amendments that were dealt with earlier today. Our specific current concerns are the seeming lack of integration with the expedited power of attorney in Bill 108. Bill 108 seems to give powers which Bill 109 takes away. We recommend that the registered power of attorney in Bill 108 apply in sections 12 and 19 of Bill 109 so that a health practitioner will call the attorney when a person is incapable with respect to treatment.

Also of great concern to us is the deletion of provisions for emergency admission to a psychiatric facility that were in the previous draft. This draft may deny emergency admission during an acute psychotic episode when an incapable person does not meet the dangerousness standard of the Mental Health Act. There must be authority to admit in an emergency, and we are urging you to reinstate the original clause.

Another addition of great concern to us is the new section 29.1, extending the powers of the Consent and Capacity Review Board. This section gives the power to second-guess decisions made by the grantor and the substitute decision-maker about what treatment an incapable person should receive and where they should receive it.

A person's decision, made while capable, can be superseded by an appeal which he or she brings when they become incapable. This defeats the whole purpose of the registered power of attorney and therefore we are recommending the deletion of this section.

We recommend that the public guardian and trustee supervise substitute decision-makers, not the Consent and Capacity Review Board. In order to prevent abuse of powers by substitute decision-makers, the role of the public guardian and trustee needs to be enhanced.



We ask you to listen to families of people with schizophrenia and to take into account the unique needs of their relatives when you amend these bills.

I would be happy to answer any questions. We have made more detailed recommendations, and we have drafted some amendments. We know some of our amendments are rather difficult, but we will be pleased to answer your questions.

**The Chair:** Thank you very much. Mrs Sullivan.

**Mrs Sullivan:** Because this is such a comprehensive brief, I know we're going to want to take a longer time to review the matters that are considered and put forward in it than is going to be allowed to us this morning.

There are a couple of things I would like the counsel for the Ministry of the Attorney General to respond to, and I'll give him a second of notice. This is not the first brief to discuss the amendments that have been put forward to the role of the Consent and Capacity Review Board in second-guessing a grantor and the substitute decision-maker, and I would like the counsel for the—

[Failure of sound system]

1134

**The Chair:** I call this meeting back to order. Mrs Sullivan.

**Mrs Sullivan:** I wanted to give notice to the counsel. I hope he will come to the table in a second to respond, for the record, with respect to that situation.

The other question I wanted to raise—and I suspect it will probably best be answered by the parliamentary assistant to the Minister of Citizenship—is an issue that the Friends of Schizophrenics have brought to the committee on page 4 of their paper relating to the composition of the Advocacy Commission.

With the amendments that have been put forward, the wording has changed to require a majority of members of the commission to be vulnerable now or people who have been vulnerable. The Friends of Schizophrenics have rightly pointed out that the definition of vulnerability now included in the bill would mean that a vulnerable person who is now vulnerable would need the services of an advocate.

I wondered if that was the intention of the minister in putting forward those amendments—or if in fact the wording of the original bills as presented reflected the real intent of the Ministry of Citizenship. I believe Mr Wessinger also commented on this just before the break. It is of some concern not only to members of the committee but to many groups appearing before us. Perhaps we could start with the parliamentary assistant and then go to Mr Fram.

**Mr Malkowski:** May I please ask our policy assistant to clarify what the intent of the amendment is?

**Ms Mary Beth Valentine:** The amendment that came forward was intended to clarify with regard to some of the concerns some groups had stated previously. Since the amendment has come forward, as you've pointed out, other groups as well as OFOS have raised the concern. I don't think the wording of the act has actually captured the policy intent. We have drawn this to the minister's atten-

tion and I do believe it is an issue she will want to revisit after the end of the public hearings.

**Mrs Sullivan:** Could we have a commitment from the parliamentary assistant that we might see a proposed amendment from the ministry in this area tabled as quickly as possible, if possible before public hearings are completed? This is not the first group to bring it forward. Members of the committee have raised the issue, including members of the government. We're quite concerned about it and we want to know and be able to see in writing what the real intent of the government is in this area.

**Mr Malkowski:** This issue will be brought up and discussed with the minister. We'll have to get back to you later.

**Mrs Sullivan:** I'd like to emphasize that as quickly as possible would be useful.

**The Chair:** Did Mr Wessinger or Mr Fram want to respond?

**Mrs Sullivan:** I'd like Mr Fram to respond to the other point.

**Mr Steve Fram:** As I understand the question, it was whether the decisions of a guardian with the authority to make treatment decisions or a person holding a power of attorney that's been validated could be taken to the review board under Bill 109. Section 12 of Bill 109 says, "Sections 10 and 11"—that's the rights advice, the appeal provisions—"do not apply if the person has a guardian of the person appointed under the Substitute Decisions Act, 1992, who has authority to consent to the treatment, or an attorney for personal care under a power of attorney that confers that authority and has been validated under that act."

In both cases the review procedure under Bill 109 would not apply if you had a validated power of attorney, whether expedited or not, or if you had a guardian with authority to consent to treatment.

**Mrs Sullivan:** I'm going to ask, if I may, the representatives from the Ontario Friends of Schizophrenics if there is any further clarification they want on that point. Again, this is not the only group that has spoken about the possibility of the board second-guessing either the incapable person's decision while capable or the substitute decision-maker's decision.

**Mrs Etchen:** We are a very small organization, we don't have a lot of money and at the present moment we are without legal counsel because of that. However, we did ask for an interpretation of this clause. The interpretation we got from the legal representative we asked several months ago differs from that of Mr Fram.

The interpretation we had of subsection 29(1) was that a person may apply to the board for a review of a decision to consent on the person's behalf. That was interpreted for us as meaning that an incapable person could apply. Maybe there is room for discussion with Mr Fram or maybe it needs clarification and redraft. Our interpretation some time ago was that an incapable person could apply.

1140

**Ms June Beeby:** I want to make the point that it needs to be very clear. This is an important way for us to get help for our relatives. One of the things we've found with the



Mental Health Act is that there are different interpretations, whether it's education or legal interpretations, but it's given us a lot of trouble. If we have the same problem with this act as we have with the Mental Health Act, it's going to create a lot of problems for families, so it really needs to be clearly written and clearly understood by those who must implement it, which is families as well as the legal profession and mental health professionals.

**Mrs Sullivan:** Perhaps Mr Fram could put his mind to reviewing those sections again and determining if indeed there should be an additional clarification so that there is very clear understanding of the nature and intent of that section.

**Mr Jim Wilson:** Thank you very much for your very thorough brief. It seemed to me that when we last met here at the committee and were talking about people suffering from schizophrenia, and in conversations we've had at committee here with members of the government side, one of the selling points, at least in my mind, of this legislation where it might be helpful to families trying to help a loved one who suffers from schizophrenia was in Bill 109, section 22, emergency admission to a psychiatric facility. I'm very disturbed, as I think you are, to learn that that's been dropped. The reason, which I didn't know and which you've kindly pointed out, was Mr Sharpe's reasoning that it wasn't intended in the original draft.

Do you want to comment on that? You know my family background and involvement in this issue, and to me that was one of the selling points and perhaps one of the benefits of this legislation to such families, in that it gave more teeth, I thought, than the current Mental Health Act.

**Mrs Etchen:** Frankly, we were very pleased with the first draft of this bill, as you were. We are as anxious as you are about this second round.

The problem with the emergency admission to a psychiatric facility under the Mental Health Act is that it's a dangerousness test. What we are seeking is an emergency; it's a true medical emergency. Schizophrenia is a biochemical disease of the brain. People need emergency treatment of the disease itself, regardless of whether they're dangerous or not. The dangerousness committal criteria under the Mental Health Act can still apply, but there has to be a way of admitting people who are in a case of a medical emergency because of the disturbance in their brain.

June has already referred to the problems of interpretation of the Mental Health Act. The dangerousness test is one of the really significant differences of opinion among the medical profession and the legal profession about what it means. Sometimes we just cannot get our relatives committed because doctors think there isn't a danger. In that case, we need a way of getting the person into the hospital, because it is an emergency. We wouldn't go to an emergency ward, we wouldn't call the police, as Sabatino's brother did, unless there was an emergency, and in many cases the dangerousness test can't be met.

I guess one of our pleas to you is to please help us get our relatives into a hospital in a medical emergency where the committal criteria of dangerousness are not applicable.

**Mr Jim Wilson:** I very much appreciate your comments on that. Perhaps I could ask the parliamentary assistant, Mr Wessinger, what the ministry's thinking is in this area and whether we can get an assurance that it will very seriously consider the concern that's just been raised.

**Mr Wessinger:** The intention of the ministry is to not change the existing law with respect to the Mental Health Act. I have some sympathy with the Friends of Schizophrenics in the sense that I think there have been some difficulties with psychiatrists not interpreting the Mental Health Act correctly. That is our position, that they have not interpreted correctly in certain instances where people ought to have been admitted; that the law is fine except that it's a problem of the question of interpretation. For whatever reason, some members of the psychiatric community, or some medical doctors who perhaps are not familiar with the whole question of schizophrenia, don't understand the situation and therefore refuse to admit. Certainly it's recognized that there have been difficulties in this area, but the whole intention is to leave the existing law as it is under the Mental Health Act.

**Mr Jim Wilson:** If the ministry agrees or feels that the existing law is sufficient, then why—I think there was recognition in the first draft of this legislation that there is a problem with the Mental Health Act in these provisions. I'm clearly on the record in agreeing with you, Mr Wessinger, at that time that this would be an improvement over the existing situation. Now we've gone full circle, we're back to where we were, no longer a selling feature of this legislation. You've just lost my total support in this particular area.

If your ministry is satisfied with the current Mental Health Act, what then are you going to do for these physicians who are reluctant to apply the dangerousness test as you deem it should be applied?

**Mr Wessinger:** I think the point has been raised by several people submitting today that it's a question of education. I think that's been one of the major problems with the whole question of the common law that has also come forth in many instances, that there's a lack of understanding by many members of the health professions with respect to the common law situation—concerning many areas, by the way—the whole question of consent in the common law. That undoubtedly is the reason for the legislation: to have in effect the common law codified so it's understandable to the health professionals.

**Mr Jim Wilson:** That wasn't a very helpful response, Mr Wessinger. Perhaps Mr Fram could help us out in this area. I think you know, Steve, that my views on this were that draft 1 wasn't too bad in this area. Can you tell us where you're at now?

**Mr Fram:** I'm a bit confused about the question. What we tried to do is to address the concerns of ongoing care for people with schizophrenia and other mental disorders, apart from the Mental Health Act. The Mental Health Act has a very limited purpose: It's the exercise of the state's power to confine someone who's dangerous to himself or others. That's all the state power can be used for.



The Friends of Schizophrenics and psychiatrists and people concerned about disorders have said that this is a pretty sad state, where people aren't mentally capable of making choices yet they're not critical enough to get treatment. So the answer in the guardianship provisions is to say that if somebody's not mentally capable and psychiatric treatment is appropriate then the court can make an order in a guardianship order that says—this is the amendment we proposed in this round—that admission for psychiatric treatment from time to time may be administered, and the guardian controls.

The other side of that is that if someone has a guardianship order the court can say, "Guardian, as these episodes arise, you as guardian can take the person and have him admitted to a psychiatric facility"—assuming that the psychiatric facility will take him—"for care and treatment that you've ordered."

Theoretically then, somebody could be left in a psychiatric facility on the word of his guardian. So the corrective provision that goes with that—or just the watchdog provision, because there's no provision for review every three months or every six months—subsection 29.1(1) of the Consent to Treatment Act, says, "A person may apply to the board for a review of a decision to consent on the person's behalf to the person's admission to a hospital, psychiatric facility or health facility referred to in section 19 for the purpose of treatment."

1150

If you're stuck there for four or five months and you think that the time's over and you want somebody to review whether that's the appropriate placement, then you can apply to the review board to have a determination if that's appropriate or continues to be appropriate. That's how the two provisions fit together, but the design of this is to shift from the Mental Health Act being the sole means of addressing the needs of people who have episodes to the treatment taken from the other point of view, not society's needs to protect but the individual's need for treatment. That's where guardianship and validated powers of attorney and powers of attorney come in.

**Mr Stephen Owens (Scarborough Centre):** I have a question to the ministry on the Substitute Decisions Act. In terms of the recommendation regarding the addition of the word "understands" under subsection 47.1(1) and paragraph 50(2)4, has there been any thought given that in fact this may be a good way, in the first instance, to tighten up the language and, in the second instance, bring the language to its natural conclusion? Is there anybody here? Who's doing the Substitute Decisions Act?

**Mr Fram:** If I understood the question correctly, you're referring to the suggestions by the Friends of Schizophrenics to alter the definition of "capacity" to make it "power of attorney."

**Mr Owens:** That's right.

**Mr Fram:** Of course I've just seen it this morning. Let me try and tell you what we're trying to balance. We're trying, with the definition and the change of definition, to be able to reach down in the case of developmentally handicapped people, to be able to get as many as

possible to be able to choose who will be their substitute under a power of attorney.

Everything we do to tighten the definition of capacity to make the power of attorney deprives all those people who are moderately to seriously developmentally handicapped of the right to choose somebody who will be involved in their lives on an ongoing basis.

My first-blush look at this is to say we'll take a look at it, but it seems to me that the very tightening of the ability to make the power of attorney will deprive an enormous number of people of the ability to choose someone to act for them and force numerous families to go the guardianship route where it's unnecessary and inappropriate.

**Mr Owens:** My question is to the presenters with respect to your comments on guardianship. I understand where you're coming from, and I've spoken with Ms Beeby on a number of occasions. What I'm trying to do is find a comfort level. Where do you balance the ability to put people under guardianship in an easier manner, which may or may not lead to abuse, versus a tighter and perhaps more onerous process, as you seem to feel we have in this piece of legislation? Do you have any suggestions as to how we can balance those two needs?

**Mrs Etchen:** We thought we had tried to strike a balance. We understand the problem Mr Fram has mentioned that there are people who are developmentally handicapped who may need to have someone reach down to their level to make the power of attorney or the guardianship order. But we have the same problem. There are many people with schizophrenia who, once the first episode is over, become a chronic case and their capacity never returns to a substantial level. Many of these people too will be anxious to take advantage of this section, the power of attorney for personal care.

What we're concerned about is that the disease is a fluctuating disease, so there may be people who are capable now, who give instructions to the person who has their power of attorney, but later on in an episode they become incapable and they revoke those instructions. They still have the capacity to revoke them. We're concerned about their not being able to have the insight into their own disease to understand what they're doing.

This seems to give an incapable person the capacity to overturn his capable wishes. So what we're suggesting is that the test be that they understand what they're doing. We think that gets to the level of reaching down to the incapacitated person to some degree, to the person who is developmentally handicapped or the person with schizophrenia who has not been able to rise very substantially back to a level of capacity again. We think, at least we hope, we've reached a compromise.

**Mr Owens:** Thank you.

**The Chair:** Thank you, Mr Owens. Mrs Etchen, Ms Beeby, on behalf of this committee I would like to thank you for taking the time out this morning for your presentation.

This committee stands recessed till 2 pm this afternoon.

The committee recessed at 1157.



## AFTERNOON SITTING

The committee resumed at 1414.

## CAMPAIGN LIFE COALITION ONTARIO

**The Chair:** I call this committee back to order. I'd like to call forward our first presenters for this afternoon, the Campaign Life Coalition Ontario. Good afternoon. As you realize, you'll be allowed a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Ms Clare Dodds:** My name is Clare Dodds.

**Mr Kurt Gayle:** My name is Kurt Gayle.

**Ms Dodds:** Campaign Life Coalition Ontario is a provincial organization working in the political arena on the issue of euthanasia. We are pleased to be able to present our concerns on the proposed legislation.

We oppose these bills in their entirety and gave our reasons in our original brief to this committee in March. The amendments to these bills do not even begin to deal with the substance of our objections. I will summarize our main objections.

The first is the role of the family. The bills diminish the rights and responsibilities of family members when it comes to ethical decision-making regarding vulnerable persons and incapable elderly patients.

Second is the patient-doctor relationship. The existing legal and ethical parameters of the patient-doctor relationship in the province of Ontario have met the health care needs of the public. An underlying premise of the proposed legislation is that doctors, unless provided with freedom from legal liability, routinely overtreat their patients. There is virtually no evidence to support this premise.

Third is the right to refuse treatment and informed consent. Patients already have the right to refuse medical treatment under common law. Also, how can one give informed consent in a living will about some future unknown medical condition, under unknown circumstances, at an unspecified age and location, with no documented health history leading to this particular event and no opportunity for prognosis?

Fourth is a formula for cost containment. These bills are a thinly disguised mechanism to reduce patient services and cut health care budgets. We strongly object to such cost containment measures being practised on some of the most vulnerable members of our society.

Fifth is the right to nutrition and hydration. Treatment is defined so broadly in Bill 109 that it could be interpreted to include nutrition and hydration. This could lead a guardian or attorney for personal care to request that food and water be withdrawn, in effect permitting the patient to die from starvation. Proponents of euthanasia consider the withdrawal of food and water to be the first step towards active euthanasia.

Sixth is living wills. The practical effect of Bill 108 is to introduce living wills to Ontario. The underlying premise

of a living will is that doctors, unless threatened with legal action, routinely overtreat their patients. It undermines the professional judgement of the physician in that it compels the doctor to act in a certain manner dictated by a written document that could not possibly encompass all scenarios.

I will expand on two of the six points. First, living wills: Bill 108, subsection 47(5), will legalize living wills in Ontario. Why should we be concerned about that? I'll answer that question by reading a letter which appeared in the *Toronto Star* not long ago.

"Several bills before committee at Queen's Park would for the first time legalize living wills in Ontario.

"A powerful lobby is promoting living wills as a measure to improve communication in health care and to protect each person's right to self-determination.

"Of course, in reality few of us have ever known—or will ever know—a terminally ill person kept alive against his or her will and most of us and our families communicate with our doctors just fine.

"But we are aware that drastic measures are already being undertaken to cut health care funding. We also know that in the next 10 years the percentage of the population over the age of 65 will increase by 55%.

"Living wills are a foot in the door for future justification of drastically reduced levels of health care, and early deaths for many of our most vulnerable, elderly, poor. Succinctly put, living wills are a forerunner of euthanasia in Ontario!"

Second, I'll deal with cost containment. "Improving communication in health care and protecting each person's right to self-determination" are some of the high-sounding phrases used to promote the living wills and advanced directives which would be legalized by these bills. However, the real underlying reason for the proposed legislation is cost containment.

In the United States, when the patient self-determination act became federal law eight months ago, the US federal government was really putting pressure on health care providers to put pressure on citizens to relinquish medical care. US government studies have estimated that the act could trim billions of health care dollars in the US, thus clearly identifying the act as the cost containment measure it is.

Here in Ontario, in this era of economic downturn and government efforts to control overall expenditures by cutting health care costs, dressing up living wills as enhancing patient self-determination and improving communication is much like the government of Ethiopia pushing crash dieting to improve people's health. Posters in Addis Ababa might exhort the citizenry to, "Live healthier on 600-calorie-per-day diets!"

1420

We need to be honest with one another. This is 1992 and we have three important factors coming together: First is the economic downturn and less government money to spend. Containing health costs is viewed as part of the government's overall cost containment program. Second, the elderly, as expected, consume per capita a disproportionate amount of



the health dollar. Third, the percentage of elderly people in our population is rapidly increasing.

Points 1 and 2 require little elaboration. Point 3—the rapid greying of the population—can best be illustrated by referring to an article from the *Globe and Mail* from April 2 of this year, “The Greying Of Ontario.”

“Over the next 10 years, Ontario will have a 55% increase in the number of residents over age 65, or about 1.5 million people, according to figures in a study by the city of Toronto’s long-term reform committee.

“Over the next 30 years, the number of people over age 85 will grow by 161%, and the proportion of Ontario’s population requiring long-term care will more than double....

“So what’s the point? The report says that long-term care reform has to be a major priority of government of all levels over the next few years if society is to cope with an older population.”

How will the government of Ontario cope with the increasing percentage of our population over the age of 65? Other than the current living will legislation, what long-term care reform does the Ontario government have in mind? Let’s examine another *Globe and Mail* article that appeared one week ago today.

“Despite waits ranging from several months to more than two years at nursing homes, chronic-care hospitals and homes for the aged, the cash-strapped Ontario government has frozen the number of long-term care beds in the province.

“A recent survey found that 4,300 seniors are on waiting lists for the approximately 170 institutions in the Ontario Association of Non-Profit Homes and Services for Seniors

“The non-profit association projects that by 2010, under the policy of zero growth in long-term care facilities, there will be fewer than four beds available for every 1,000 people over 65.” If the last sentence doesn’t shock us, it should.

“A seniors’ coalition that recently conducted public hearings on reforming long-term care was told that chronic care beds are less than half the cost of acute care hospital beds.

“Yet chronic care hospitals are closing beds because they can’t meet expenses because of a cap in funding from the deficit-plagued NDP government.

“The Sisters of St Joseph, who run Providence Centre in Toronto, are phasing out a 54-bed chronic care wing even though about 150 people are on a waiting list to enter the hospital.”

Mr Murray Fisher, who is the son of an elderly woman who has been waiting for two years for a chronic care bed, “calls the lack of bed space a crisis and wonders why the government doesn’t build more homes for the aged.

“The geriatric problem is certainly increasing, and it’s going to be far worse in 25 years. I’m 61. So I’ll be in there myself if I make it.”

Everywhere we turn, the cost containment policy impacts disproportionately on the elderly. If the present Ontario government were genuinely interested in providing complete health care for our senior citizens, it would certainly, among other measures, be funding a rapid expansion of chronic care beds in Ontario. The fact that they are not leads us to conclude that they have few plans for the

elderly other than persuading them into accepting drastically reduced health care through the use of living wills.

Just to repeat, we need to be honest with one another. Living wills would have our seniors volunteer to receive less-than-standard medical treatment in order to cut health costs. Whether in the US or Ontario, containing health costs is the real reason for this type of legislation.

The firm position of Campaign Life Coalition is that these bills are totally unacceptable. The amendments offered have not substantially affected our basic objections. We live in a wealthy society, compared with many around the world, and we must be willing to sacrifice hundreds of non-essentials and luxuries before we ask even one of our vulnerable elderly to volunteer to die.

**Mr Curling:** Thank you for your presentation. I think all presenters who come here have their point of view because that’s what the committee’s all about, to look at the different points of view.

Putting aside that this government is strapped for money—maybe all governments in Canada these days are strapped for money to fund programs adequately—one of the areas of course that all governments have recognized, even the Liberals when they were in power, is the escalating costs of health care and that something has to be done. The NDP government has to wrestle with that as much as the Liberal and Conservative governments had to wrestle with that.

Would you say that there are vulnerable people in our society who need to be protected and that there is legislation that should be in place to do so? In other words, whatever is on the books right now needs to be improved. What I’m getting from you, too, is that the entire bills should not be here at all because that’s not where the emphasis should be. Am I reading you right?

**Mr Gayle:** That’s correct. I believe it would be fair to say we reject all the bills categorically and totally. We don’t think they’re amendable at all. We don’t think the amendments offered do what they claim to do. We think the problem that will face elderly people in our society in the future is not to be defended from having too much health care but to be defended from having not enough health care.

Somehow the media, particularly in the United States, has cooperated with the notion of saying that there is a significant number of people who are going to be wired up, tubed up and kept alive against their wishes and that we need legislation to protect them when in fact the opposite will increasingly be the case. Budgets will be cut and priorities will be set which ignore health and education increasingly.

What disturbs us particularly is that this government, which is known for having very progressive social ideas on many issues, has allowed itself to be hooked up with what is an American phenomenon. The health care system in the States—and as a draft dodger from 25 years ago, I know—is a disaster. We don’t need the American health care system.

In order to contain costs in the States, they have not just two tiers; they have three and four tiers. Elderly people



and people without insurance are prevented from getting adequate health care. The legislation passed federally and in the 50 states is meant to enshrine a system where a patient who comes to a hospital is presented with documents to sign and really signs off his or her right to have adequate health care.

I'm not suggesting that anyone in this room is motivated by those motivations we see from the States, but it's very funny to see the NDP government ape an American plan without having, we feel, any legitimate cause to do so.

**Mr Curling:** I've come to some of the conclusions you have come to, too, that the NDP government will talk the talk but it really can't walk the walk. We have realized that their intention of course is to look out for the disadvantaged and they may be the only ones who can do so. We have shown that position after position has been reversed because they're not capable. In the meantime, as the opposition we are here to make sure that the place doesn't go amok with their manner of governing.

I feel there has to be a bill or legislation to protect the vulnerable, but I'm still getting from you that it's not needed. There are families and friends who are assisting some of the vulnerable people along in society. Do you feel the laws that are on the books now are quite adequate?

1430

I asked the question before, but I want to see if those people in that system need any support—in other words, proper laws—to give them that kind of support along the way. I'm not saying that this one they have here is the correct one, because many of the people come before us and say, "It needs a lot more improving, and as a matter of fact there's not even a cost factor to it." The government doesn't even know what it's going to cost. Again, is it necessary that we have a bill, a law, on the books that will support those families and friends who are assisting the vulnerable people?

**Mr Gayle:** I understand your question, Mr Curling. It is our feeling that this legislation will not do that job, that it needs to be begun from scratch. This is deficient from the ground up, in our view, and this will not do that job to the extent that it needs to be done. I suppose our underlying position is that the existing common law is adequate, and if it ain't broke, don't fix it, and we don't think it's broke.

**Mr Tilson:** All of these various pieces of legislation give medical people—doctors, nurses, anyone in the medical profession—all kinds of more responsibilities and duties. Should there be any provision in any of the bills that protects doctors, nurses, whoever, from frivolous claims that they aren't making their decisions properly? The medical profession is being sued left and right, sometimes quite justifiably and other times not, but it seems to me when you create all this administration—some of it's good, a lot of it's bad; at least from our perspective, it's not good—but there doesn't seem to be anything that protects anyone in the medical profession from frivolous claims. Have you any thought on that?

**Mr Gayle:** Yes. That underscores our basic contention that what you have here is an American piece of legislation that's been warmed over and redressed for Ontario. My

brother's a practising physician in West Virginia, and his malpractice insurance is sky-high. There is a problem with that whole phenomenon, and ambulance-chasing lawyers. The Americans have dug them a hole, and I don't know how they're going to get out of it.

The situation in Ontario is dramatically different. Malpractice suits are not only manageable; the courts deal with them differently. We have a whole different practice and experience.

Again, the thing I think should be troubling is that that sort of approach, suing doctors frivolously, will be imported into Ontario the closer we ape legislation and patterns from the States. I share your concern that, should that arise, we are in deep trouble where we then want to put structures in place to protect doctors from that.

**Mr Tilson:** In your studying of other jurisdictions, are there proposals in any of the American states or any other jurisdictions where legislation is being put forward to protect people in the medical profession from sometimes literally wacko claims?

**Mr Gayle:** I think the AMA is fighting the lawyers state by state, and I don't know if it's having any real success. I'm not rooting for either organization in a certain sense.

**Mr Tilson:** The second question I have has to do with the power of attorney legislation. People in the legal community are telling me that if anyone comes into their office and asks an opinion whether he should be an attorney and act for people who have either physical or mental problems and he's going to act on their behalf, they're saying: "We recommend that you don't do it because of this legislation. You're opening up the door to be sued left and right because of all the many, many requirements that are being put on you by this legislation." Have you any thoughts on those allegations?

**Mr Gayle:** The level of bureaucracy in the proposed legislation is astonishing. I think not only the \$20-million to \$30-million figure to fund it has been cited, but I think it will create a virtual army of people—hospital people and doctors and lawyers—to interpret what the particulars of this legislation mean.

Quite aside from that, the legislation—I think inappropriately in Ontario—removes doctors from responsibility, removes health care people from responsibility, in ways that are inappropriate. With a vulnerable elderly person in a hospital bed, I think we still, as a society, want to say that that person, unless terminally ill, is entitled to all normal health care. I guess the medical profession is happy about this. It seems to unplug them from responsibility, again in inappropriate ways.

**Mr Tilson:** Again, I'm looking specifically at the person who's been given a power of attorney, not necessarily the medical people—the layman who is assisting people. I've sort of changed to another topic from my first question. The legal people are saying, "You're crazy to act as an attorney because of the many restrictions that are being put forward in these bills."

**Mr Gayle:** The legislation is so new in most jurisdictions in the States and certainly in Canada—it's not yet passed into law—that it would seem that there would have



to be that concern that there could very well be an explosion of civil litigation, questioning the role of advocates, questioning the role of people with powers of attorney for health care, the way they exercised them, that they did it in a fashion that didn't represent the—

**Mr Tilson:** If I could ask one further question, and it has to do generally with your presentation, and that has to do with the whole subject of what rights I have, whether I'm an elderly person or whether I've had a stroke and I can't perhaps communicate. I raised the question this morning about the parents who have the handicapped child and are fearful of all the funny pieces of paper they're going to have to complete now and fearful of watching advocates come and of these agencies that are going to be coming and watching them, and all they're trying to do is to raise their handicapped children under very difficult situations.

How far should a government go in getting involved? At the same time I'm sure that we can all see examples where vulnerable people have been taken advantage of. But how far should a government go in getting involved in all this?

**Mr Gayle:** In our reading of the proposed legislation, the bureaucracy set up and the procedures to go through and the interpretations and meeting back and forth will be bewildering for a lot of lay people such as us. We feel the best approach would be to scrap all of the proposed bills and to start from the beginning again.

Again, with all respect to the people assembled here, this is very, very bad legislation, and I think from a point of view of history, you will be looked back upon with disfavour by subsequent generations. This is something that will take us into an area where we haven't gone before and it's very contentious and it's full of moral and ethical dilemmas and it's just a mistake to pass this legislation.

**Mr Malkowski:** You know that for many years vulnerable people have experienced neglect or abuse, and the O'Sullivan report strongly recommends the establishment of an advocacy system. Do you think it is important to have legislation that protects a vulnerable person from neglect or abuse?

**Mr Gayle:** I agree with the principle you've raised. It's extremely important. One of the things that feels so good about being a Canadian living in Ontario is that we, as a society, are on record for several decades back as agreeing through our medical health care system and in other social ways to protect all of our citizens, and I agree that it would be very important to have such legislation.

Our feeling, however, is that this legislation creates more problems than it solves, and certainly the submissions you have heard before from people who are advocates for vulnerable people underscore that point.

1440

**Mr Malkowski:** Do you perhaps have specific recommendations you could suggest that would improve the legislation?

**Mr Gayle:** As I say, and I hope my remarks are not interpreted as being arrogant in any way, our organization

feels that the legislation is irredeemable, that it should be scrapped and that the process should begin again.

**Mr White:** I just have a couple of brief questions. You made some very interesting points with regard to the living will and of course the comparison between our own legal system and that in the United States and the health care system, the differences and the dangers of becoming more like the American systems.

**Mr Gayle:** A very frightening danger.

**Mr White:** I want to pick up on the first point of your objections, which was in regard to the role of the family. My focus here will be on Bill 74. I guess what impressed me with Bill 74, in the amendments, is section 15.2, where it specifically says that the advocate shall—not may or might or could possibly, but shall—ask the vulnerable person whether there are family members or friends who could provide assistance and the advocate will assist family members and friends in their efforts to provide assistance to that vulnerable person. In other words, in law the role of the family seems here, to my mind, to be enhanced. It specifically says that the advocate has to, wherever there is a family, wherever there are close friends, use those people to assist that vulnerable person. Of course, with vulnerable people we are talking about a range of people, not people who are terminally ill; in fact, most of them I would think would not be. But wouldn't you consider that to be an enhancement of the role of the family in these situations with vulnerable adults?

**Mr Gayle:** This committee deserves the credit of having gone through the presentations made back in the spring and having responded to them. With Bill 74, section 15.2, Bill 108, subsections 32(3.1) and 32(3.2), subsections 63(4.1) and 63(4.2), and Bill 109, subsection 16(5.1), we sat down and debated for a long time these matters, and we feel there was a genuine effort on your part to meet some of the objections of some of the presentations that were put forward.

On the whole, though, after lengthy discussion, we found they really didn't address in a significant way across the board the basic concerns our organization had. Again, I don't wish to appear ungrateful. You raised the point and I'm acknowledging that these were changes in response to earlier points made some months ago, but we don't feel they are adequate. They don't address the underlying difficulties with these bills.

**Mr Wessinger:** I'd like to make a couple of comments. First of all, I think there is a misapprehension about the reason for this legislation with respect to living wills. This legislation has been under way for the last 12 years approximately, through three different types of government, and the key issue is recognizing the autonomy of the individual in determining his own health care. That is the basic premise of the legislation.

I'd like to comment on the other aspect. Mr Tilson somehow indicated there was no protection for liability in this bill. There are two sections of the Consent to Treatment Act, section 24 and section 25, which deal with the matter of protection from liability.

First of all, with respect to medical practitioners, "If treatment is administered to a person with a consent that a



health practitioner believes, on reasonable grounds, to be sufficient for the purposes of this act, the health practitioner is not liable for administering the treatment without consent.”

Similarly, if a medical practitioner refuses to administer based on “believes, on reasonable grounds,” he is again exempt from liability. If the practitioner administers treatment under the emergency provisions, he is not liable for liability at all. In addition, an individual—not a health practitioner—who “gives or refuses consent to treatment on another person’s behalf, acting in good faith and in accordance with this act, is not liable for giving or refusing consent.”

I think a fair amount of provisions in the act cover the question of protection from liability. I just wanted to clarify that.

**Mr Gayle:** If I might just respond to the first of the points—I know it wasn’t in the form of a question—in our view it’s not accidental that though aspects of this living will were considered worthy of discussion for perhaps a dozen years before this legislation was put forward, it wasn’t acted on.

We have documented proceedings from euthanasia organizations in Canada and the States going back some years. Not only were they not making headway; they said they needed to start with living wills. They felt very stymied because they could get nowhere with living wills. They said what they needed was a recession. We’ve got a recession and you’re moving on it. You weren’t moving on it 12 years ago, or 10, or eight, or six. You’re moving on it now.

**The Chair:** Ms Dodds, Mr Gayle, on behalf of this committee I’d like to thank you for taking the time out this afternoon and giving us your presentation.

ONTARIO ASSOCIATION OF CHILDREN’S  
AND YOUTH INSTITUTIONS

ONTARIO ASSOCIATION OF RESIDENCES  
FOR TROUBLED YOUTH

**The Chair:** I’d like to call forward our next presenters, from Ontchild and the Ontario Association of Residences for Troubled Youth. Good afternoon. Just as a reminder, you’ll be allowed a half-hour for your presentation. The committee would appreciate it if you keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you’re comfortable, could you please identify yourself for the record and then proceed.

**Ms Claire Braseliten:** Claire Braseliten.

**Ms Julie Ann Wolfe:** Julie Ann Wolfe.

**Ms Andrea Rifkin:** Andrea Rifkin.

**Ms Gita Schwartz:** Gita Schwartz.

**The Chair:** Please proceed.

**Ms Rifkin:** Introducing OARTY, the Ontario Association of Residences for Troubled Youth is a provincial network of organizations providing residential programs in treatment settings. These include group homes, specialized foster care programs and other residential facilities. All OARTY members are funded on a per diem basis and are licensed and regulated under the Child and Family Services Act.

Formed in 1985, OARTY has a membership of over 40 agencies. Together we represent over 800 beds across Ontario. We care for a wide range of children. Some of these children are developmentally challenged, physically and sexually abused, emotionally disturbed, medically fragile children, children with autism and children who are hard to serve. We serve children of all ages and aim to prepare them for independent adulthood where possible.

Our major areas of concern are the quality of children’s services in Ontario, standards of care, staffing needs to include training and upgrading, investigations of abuse and safeguards for children in residential care. In that our children represent our future, we are deeply committed to their health, safety and welfare.

**Ms Wolfe:** Introducing Ontchild, Ontchild is an acronym for the Ontario Association of Children’s and Youth Institutions. It is a non-profit charitable organization formed in 1976 and dedicated to the services of children and youth in Ontario. Our Ontchild association represents over 40 organizations across the province, member agencies whose responsibility is to serve children and youth in both residential and non-residential care capacities.

1450

All Ontchild agencies are regulated under the Child and Family Services Act of 1984 and are transfer payment agencies of the Ministry of Community and Social Services. All Ontchild agencies are non-profit and governed by local community volunteer board members.

Our commitment is to improve the quality of care of children and youth in Ontario, and our work is with more than 10,000 young people on an annual basis. One of Ontchild’s goals is to respond to and make recommendations on government policies affecting children and youth, based on the input of our member agencies.

Regarding these proposed Bills 109 and 110, our member agencies across the province have expressed genuine concern. We appreciate the opportunity to come before you today to make this submission to you, the Ontchild/OARTY joint submission to the standing committee on administration of justice regarding the proposed consent to treatment legislation and amendments to the Child and Family Services Act, Bills 109 and 110.

Ontchild and OARTY represent 90 organizations across Ontario that provide both residential care and non-residential services to children and youth in this province. We serve vulnerable and troubled youth, developmentally challenged youth and the medically fragile child. We serve over 12,000 clients annually.

**Ms Rifkin:** Together we represent the largest segment of short- and long-term residential care providers for children in Ontario. Jointly, our members’ services provide approximately 1,600 residential beds through our residential programs.

**Ms Wolfe:** The children in our care have many difficulties. They include a history of physical abuse, sexual abuse, drug or alcohol abuse, as well as learning disabilities, severe emotional problems, major dysfunctional families, developmental delays, and often they have numerous placements within the residential care system. Many of



these children come from backgrounds of both social and economic adversity and are often hard-to-serve children with many layers of interlocking stressors. The number of stressors in an individual client's history bears a direct relationship to how vulnerable that child is. Often, the typical child in residential care has lived with mental illness, poverty and violence.

**Ms Rifkin:** In allowing children of any age the right to refuse consent to treatment, as the legislation proposes, our whole sector will be thrown into an impossible situation. Indeed, our fundamental ability to do our work is threatened. Staff in our agencies whose responsibility it is to care for these children are rendered impotent. For example, children who come into care are obliged to have medical and dental examinations. This is the current law under the Child and Family Services Act. A child will now be able to refuse this requirement. How do we meet our legal obligations under this circumstance?

**Ms Wolfe:** Another important question is that of immunization. Under the current law, we are obliged to ensure the immunization of our children. There are both legal and social consequences if this is not done. We cannot do this if a child has the right to refuse treatment, and a child may refuse simply because he or she hates needles. I know I do. Again, we are in an impossible situation.

**Ms Rifkin:** On a more simple level, children often get sick with a variety of ailments. Can they now refuse to see a doctor when they have an ear infection? An ear infection could lead to severe loss of hearing if unattended. Like a toothache, a child who hates the dentist can easily refuse treatment, knowing full well the consequences of such an action. Or, if a child is a diabetic, can he refuse his insulin shots? The list is endless and we will be put into a position where we will not be able to provide the best care for the children in our charge.

**Ms Wolfe:** All of our organizations combined look to improving the wellbeing of the children in our care. These children come to us because they have been sexually and/or physically abused, because they have been terribly neglected both physically and emotionally, because they have severe behavioural problems and because their parents can no longer care for them. Whatever the reason a child is in our care, we make plans to help him get better or to improve the quality of his life and to lessen his individual vulnerability. Our member agencies have a lengthy history in Ontchild and OARTY of successful outcomes under the existing legal framework.

**Ms Rifkin:** Our work is augmented by psychiatrists, psychologists, social workers, nurses, child care workers, kinesiologists, therapists and many more health care professionals, either on staff or as consultants. To the extent that it is possible, we do include our children in developing their individual plans of care. To allow them the option to refuse treatment by a psychiatrist or any other professional, we are stopped from doing work we think is essential for the wellbeing of the child. Children in care are often troubled and vulnerable and cannot make good judgements about their own care. To allow them this right

to refuse is to deny them protection and the opportunity to live a normal life.

**Ms Wolfe:** It is very common for children in residential care to experience acute depression as a result of the separation from their families and from their situations. The very vulnerability of these children and youth overrides their ability to decide for themselves what is best. It is often the case within all our agencies that children at any age simply do not know and are not able to comprehend the options, nor the implications of those options, that are available to them in order that they may receive assistance or treatment that will benefit them.

**Ms Rifkin:** The issue of children's rights becomes fundamentally conflicted and confused with the issue of responsibility which care givers are mandated to provide according to the existing legislation. This conflict must be resolved before any amendments to existing legislation can be addressed.

**Ms Wolfe:** If the new legislation is passed as stated, a capable child may withdraw consent to treatment in progress. Often children will resist therapy in progress. For instance, a child is reaching a point which is painful but in fact is necessary in coming to terms with sexual abuse by a parent. To stop the work at that particular time is not useful nor beneficial to the child. We as adults all know that some things are very difficult but must be faced. How does a 12-year-old know this? They will now be given the right to refuse to continue seeing a counsellor and sever the therapeutic process. Again, our ability as care givers to enact care and nurturing is severed with this additional right to withdraw consent to treatment in progress.

**Ms Rifkin:** We also feel strongly that the emergency treatment provisions in Bill 109 are inadequate. The legislation states that if a capable child is conscious in an emergency situation and frightened of a procedure, he or she can refuse treatment. A life-threatening situation must be dealt with immediately. To wait until the child is incapable or unconscious before making a life-saving medical intervention is negligent on our part as care givers.

**Ms Wolfe:** To allow children under 16 to refuse treatment plays havoc with the residential care system as well as with the adjunct systems with which our agencies interact on a day-to-day basis, and by this we're referring to police and hospital medical treatment. We are no longer professionals administering treatment plans, as chartered by the CFSA of 1984; we become babysitters with no ability to shape the experiences of these youth.

**Ms Rifkin:** The Child and Family Services Act distinguishes between children and adults. By enacting this proposed legislation and the corresponding amendments to the CFSA, we are not preserving children's rights to be children, but we are defining them as adults.

Children are in care because they are damaged or because their parents can no longer look after their needs. These children require protection and guidance. By giving children this kind of control and decision-making responsibility, we are abdicating our responsibilities as adults and are undermining the care giving system. We are asking children



to make adult decisions, which they are not capable of doing. Above all, children should be allowed to be children.

**Ms Wolfe:** We respectfully request that our positions be taken into account and that you will reconsider the passage of Bills 109 and 110 as they are currently presented.

1500

**The Chair:** Thank you. Questions and comments.

**Mr Curling:** I want to thank you for your presentation. I've heard you; I hope the government is listening, because I've had the experience of visiting some of those residential homes that care for young people. I have, as a layman, watched the manipulation by those kids, how they understand their rights, as they would say, and who should visit and when they should visit.

In part of your presentation you said, "Our work is augmented by"; that's a nice word about psychiatrists and psychologists and social workers and nurses and child care and therapists and so on. Sometimes I wish that when my kids were growing up I had all that support to call on from time to time to assist me. I think there are layers and layers, and people like yourselves are working within that system. Now here comes another—I call it the big daddy—coming over to tell you, "You may not do that," or "You may do so."

It might be helpful if a committee like this would visit some of those homes. Even visiting a home or two a day, you may not see some of that manipulative behaviour—I say that because I have watched them—but it may be helpful if they visit the institutions or visit the homes.

My question to you is, how would you feel if this legislation exempted places like yours? Keep in mind that children at home might refuse treatment; my kids might have, but they're not 14 any more. If this law exempts your homes, should they exempt private homes too? As you came to represent this area, you may answer just the part about you: Should you be exempted from this law?

**Ms Braseliten:** Our concern is certainly for the youth we represent in our organization. However, we feel that all youth and all children shall indeed be treated as children and should not be given the responsibility to make adult decisions. Although I represent the children in youth institutions, as a parent of an 8-year-old I cannot support a bill which would give my son the right to refuse treatment that I, as a parent holding his best interests in mind, deem necessary and effective.

**Mr Curling:** But I want to put the question: In your professional area, as I said, you have layers and layers of professional support. Because they have recognized that these children are abused emotionally, sexually, physically, in all ways, and the children's aid people have put them in homes where they have those supports, do you feel you should be exempt? I'm not speaking about your personal home now but about those homes. Should you be exempt from this?

**Ms Wolfe:** I don't think you can group the children in our care as being completely different from all other children they come in contact with on a regular basis. In fact, the mandate of many of our agencies is to try to establish a care plan for the individual child which has an eventual

outcome of being able to cope in society much the same as every other child. So to distinguish our children as being different and therefore needing a different set of laws, no, we wouldn't support that.

**Mr Curling:** Just a last comment: They are different, and that's why they are there.

**Mrs Sullivan:** As you know, we have had some considerable difficulty in dealing with the age issue with respect to this legislation, the question of whether the predominant test should be the best interests of the child or the right of the child to participate in and in fact make his or her own decisions, which itself involves the question of maturity versus capacity.

I think that's where there's a fundamental problem here. We certainly are, and I personally am, sympathetic to the issues of children's rights in being able to obtain medical counsel in matters, say, associated with counselling relating to sexually transmitted diseases or other issues young people may want to receive that medical counsel on and in fact may have the maturity and capacity to make decisions on about how they wish to be provided for within the context of medical treatment.

I think there are several themes emerging as we go through this second round of hearings. I hear, by example, some melding of interest between the positions of the Ontario Medical Association and the positions of the advocacy coalitions with respect to the definition of treatment by controlled act where a person, of whatever age, may be determined to have the capacity to make the decision in a different way from the age scenario, which would help us with young people whom we want to protect by being able to give them advice, say, in the sexual area, but in other areas as well.

Mr Curling has asked you if you feel your agency should be exempted from the bill. There may also be another route, as well as the controlled act route in the Consent to Treatment Act, by including the Child and Family Services Act with special provisions under Bill 110. I think there's no question that the Child and Family Services Act is directed to children with special needs and the care of those children and that perhaps Bill 110 is your appropriate place to ensure that the CFSA is not interfered with through Bill 109 and that the children who need that special care will continue to get it with the thoughtful provisos of the CFSA. Do you think that may be an alternative?

**Ms Braseliten:** Our position here is that we feel the children who require treatment should be allowed to receive the treatment, that children in our programs are not in a position to make decisions under the age of 16, so we would support the regulations as stated in Bill 74.

**Mr Tilson:** The one line I appreciate the most in your presentation is on page 7, the last two sentences, which say: "We are asking children to make adult decisions, which they are not capable of doing. Children should be allowed to be children." That probably sums up your entire presentation.

You look at other groups—and the only one I can think of is the courts, for example—that spend so much time trying to protect children from their parents, protect children



from family members, non-family members. Their concern is whether they understand what in the heck's going on or whether they understand the nature of proceedings that affect them. They spend so much time, yet they're being enabled to make decisions which, if you quoted those two sentences, they really have no business making those types of decisions. Is that really the gist of your presentation, that really children have no business making these types of decisions?

**Ms Schwartz:** Yes, I think that's absolutely correct. We're really concerned, especially with the vulnerable children we deal with, that they have an opportunity to be protected and taken care of. That doesn't exclude the fact that we all are very concerned about abuse and safeguards and so on, and we address those issues as well. The system is not perfect. But to make children responsible for so much does not allow for them to really be nurtured and to grow in the way children need to, so yes, it really does. We can go into a lot of the technical details, but that definitely sums it up.

1510

**Mr Tilson:** I'd like to ask a question to Ms Wolfe, who is billed as being a volunteer board member. We've been trying to get information out of the government as to what this whole mess is going to cost the taxpayer, what it's going to cost us, all of these pieces of legislation.

You're a member of a volunteer group. Have you analysed what this means to you, as far as getting funding, as far as the increased responsibilities, the cost? There has got to be all kinds of bureaucracy that you are going to be obliged to get into which you aren't into now, whether there are additional bodies you're going to have to hire. Has your group or have the people whom you deal with made any analysis as to what this is going to mean financially to your group?

**Ms Wolfe:** Our group in Parkdale is actually going to a meeting this week to discuss a lot of the different options and ramifications that may come into our whole program of care in Parkdale residential facilities if this does go through, because it's really hard to put a dollar figure on it. But when you've got a computer system that you fund-raised for and that is full of process and interrelation, government agency data that you've formulated—really only since 1984, when the CFSA that we're dealing with now; I mean, it is only eight years new really, and we're trying to change it again—to go back in and reformat the whole system, our agencies in residential care operate along a whole guideline of process for intake, for treatment, for treatment plans, for children exiting the program, it's really incredible.

As a volunteer on a board charged with the mandate of fiscal management of these agencies, we have not begun to look at what the changeovers would mean. But as a concerned taxpayer citizen, yes, it's a big question and it is a genuine concern of our board, causing us to meet in the summer prior to our first meeting in the fall.

**Mr Tilson:** I would think that members of the committee would be interested, Ms Wolfe, in this, once you have come to some conclusions as to what it's going to

mean to your operation. I suspect you're going to have to get a bigger computer just to match all the bureaucracy that it's going to mean. But I certainly and members of my party would be interested in what it's going to mean to you financially to continue operation, if anything.

**Ms Wolfe:** Okay.

**Mr Tilson:** I have one further question, and I don't know whom to direct that to. The question has to do with a topic that was raised on page 4. That was a suggestion that there would be conflicts with other pieces of legislation, and you've listed, in the second paragraph: "Staff in our agencies whose responsibility it is to care for these children are rendered impotent. For example, children who come into care are obliged to have medical and dental examinations. This is the current law under the Child and Family Services Act." And then you, of course, say that the child will now be in a position to refuse this. I wonder if you could elaborate on that, referring specifically to the legal conflicts that perhaps your staff will be put into, if any; or have you looked at that?

**Ms Schwartz:** There's no question that there is a conflict, because one of the things we absolutely have to do is maintain our records, which are checked on a regular basis, with internal audits and also outside audits. Licences are reviewed on an annual basis, and people will look at the children's files to make sure that the dental forms are filled out and the medical forms are filled out and the immunizations are up to date.

So I'm not sure how to answer exactly, except it puts us in a dilemma. We're not sure what it is we're supposed to do then, when one piece tells us this and another piece gives another option. So it has to be addressed. I guess that's the way to say it.

Right now it leaves us in this vacuum in between, where we're the ones who will get into trouble one way or the other. We can't say "You have to do this" and we also can't provide for the records that must be done.

**Mr White:** I'd first like to convey my congratulations on your presentation and upon the work that your association has done in the last number of years. I'm a professional social worker myself and I've worked with children's mental health centres, both as a child care worker and then later as a family therapist social worker. Many people I know in those facilities think very highly of your work; and I know, from my last 10 or 12 years, of the kinds of crises that families are into at the point where children are referred to group homes, to institutions such as you're representing. They are not easy points in those families' lives, and frequently, I think probably a third of the time, maybe a quarter, maybe a little bit less, those kids are really problematic—not all.

You point out in your brief that you like to involve the children in the treatment plan as much as possible. Sometimes it's sort of passive involvement: "This is what the treatment plan is. Do you hear me?" But it's involvement on an ongoing basis. You were funded under the CFSA. You wouldn't have many of your facilities funded under other ministries?

**Ms Schwartz:** No, not those we represent.



**Mr White:** Okay. The CFSA is still a fairly recent piece of legislation. I know from my own practice that it very much freed up that practice and allowed me to work with people who are 12 or 13 who come in on their own. They didn't have to have their parents' permission or a written form, or whatever, as they earlier did. But you would essentially not have to be concerned about Bill 109, except, as you're saying, in regard to treatment with doctors—infections, tooth decay, psychiatric treatment. What do you think causes the concerns you have, aside from those issues? I know there's a lot of concern with children's mental health centres about this provision, but it wouldn't directly impact upon your association. What do you think would cause it, for the most part?

**Ms Schwartz:** First of all, many of our agencies are also involved with treatment, so they will have consulting psychiatrists, for instance, or there will be an ongoing forum where a professional works with children. So we are involved in treatment. Often the day-to-day stuff is the most significant when a child is living in your home. But we're most concerned that when we bring in, for instance, a psychiatrist to work with our children, they could refuse that, and also refuse an ongoing medical thing that is necessary. I can't think of anything off the top of my head.

**Mr White:** It would affect ongoing treatment with a psychiatrist, but it wouldn't affect an assessment, because that kid isn't going to respond either way. At least my experience has been that the kid isn't willing to see the psychiatrist. So it affects ongoing treatment. Would your facilities be involved with ongoing treatment with psychiatrists?

**Ms Schwartz:** Definitely.

**Mr White:** In the facility?

**Ms Schwartz:** Both. Depends on the size.

**Mr Wessinger:** I just want clarification here. What you're saying is that no child under 16 has a right to make a decision with respect to a treatment, even if that child understands the information that is relevant to making the decision and has the ability to appreciate the consequences of a decision or lack of decision. You say that even in those circumstances a child would not have the right to make a decision. Is that what you're saying?

**Ms Wolfe:** The question, as Barbara Sullivan so succinctly put it, does become one of capability versus responsibility. For a lot of the children in our care it is a natural for them to say no, whether they're 16 or nine. Because of the multiple stressors in their individual case history, it becomes very difficult to define capability with the children in our care, and this is our worry.

**Mr Wessinger:** What I just stated was the common law test with respect to the question of capability: first, the ability to be able to understand the information and, second, the ability to understand the reasonable foreseeable consequences. When you look at the ability to appreciate, that may include emotional factors such as a severe trauma or, in the case of a young person, immaturity or particular background. So I suggest to you that the common law does cover the situation very well. What this legislation does is

codify, in effect, the common law. We're not changing the common law. We're not putting any particular provision in it. We're putting no age in the legislation; there's no age in the legislation. We're just continuing on the common law.

1520

If you have concerns, perhaps where they should be addressed is in ensuring that the definition of "capability" and that aspect is dealt with in a proper way. The clear intention is if a person is not able to understand or appreciate the consequences because of his trauma, then obviously he's not capable.

**Ms Akande:** Thank you very much for this presentation. Having come out of the work I was in previously, I'm somewhat familiar with children who have many of these difficulties. You put it so well when you said these children so often say no when they are addressed with anything new that comes under the general heading of treatment. Given that situation, what do you currently do?

**Ms Rifkin:** I'll speak to that with regard to the population of children that I'm associated with where they often say no and they often fight you every step of the way. The best we can do is communicate to them why it is we are going to impose the treatment and carry on and support them throughout. That's all we can do.

**Ms Akande:** Given that process you go through, do they usually acquiesce and agree to the treatment? Are there any whom you have to tie down?

**Ms Rifkin:** Yes.

**Ms Akande:** Are there many?

**Ms Rifkin:** Many. It's unfortunate. It's sometimes a function of their disorder. Sometimes the sound of fluids rushing through them, like a needle going into their arm, is too much for them to cope with. It's something that's very difficult for a care giver to understand. But if a child does have trust in the relationship, sometimes he does acquiesce and you can support him through that process.

**Ms Akande:** Given the information just read to you by my colleague about that situation actually being covered, and in view of what you've said, would you have to refer to that frequently? Would you have to rely upon that evaluation of not being able or capable?

**Ms Rifkin:** I listened to that and I don't know I agree that they're not capable, but I think the word I heard was "appreciate," because of the trauma.

**Mrs Sullivan:** Mr Chair, I wonder if we could have a clarification because of some of the words that are used. There are different interpretations of how agencies that are represented here, and children's aid societies, by example, do what they do with children. We have heard in some of the testimony before us words like "impose treatment" and so on. In fact, what is occurring is that under legal mechanisms under the Child and Family Services Act, these agencies are providing consent to treatment on behalf of those children. So while the word "impose" comes before us, and I notice that some of the government members smile when that word is used, in fact there is a legal obligation and a right and responsibility provided under the



CFSA to provide consent to treatment. It's important to get that on the record.

**The Chair:** Ms Braselton, Ms Wolfe, Ms Schwartz and Ms Rifkin, on behalf of this committee I'd like to thank you for coming here and giving us your presentation today.

ONTARIO ASSOCIATION  
FOR COMMUNITY LIVING

**The Chair:** I'd like to call forward our next presenters, from the Ontario Association for Community Living. I'll remind you that you'll be allowed a half-hour for your presentation. The committee would appreciate it if you would keep your comments to about 15 minutes to allow questions and comments from each of the caucuses. As soon as you're comfortable, would you please identify yourselves for the record and then proceed.

**Mrs Judith Sandys:** Judith Sandys.

**Mrs Audrey Cole:** Audrey Cole, chair of the OACL committee on advocacy and guardianship.

**Mr Rod Walsh:** My name is Rod Walsh, legal counsel to OACL.

**Ms Cheryl Easton:** I'm Cheryl Easton and I'm president of the Ontario Association for Community Living. We appreciate this opportunity to present our concerns, which unfortunately have not been alleviated by the recent amendments. The design of Bill 108 and the discriminatory and far-reaching effects it will have on people with severe disabilities leave us no alternative but to make every possible effort to stop it from passing into law in its present form. Audrey Cole, the chair of the OACL task force, will present OACL's concerns.

**Mrs Cole:** Although some of OACL's concerns about the Advocacy Act were alleviated by recent amendments, the principal one, that of the act's failure to provide appropriately for the needs of some of most vulnerable people in the province, remains unamended at this time. It's a glaring example of a legislated inequality based purely and simply on the severity of a disability. The Ontario Advocacy Coalition has already spoken for OACL on the need for further amendments. Other than those amendments that are required, OACL fully supports the development of an advocacy system in Ontario.

On matters relating to the Substitute Decisions Act, OACL shares with People First of Ontario and with the Canadian Coalition for Community Living, our national body, a commitment to do whatever has to be done to prevent further injustice to people with severe intellectual disabilities. OACL and People First do not have the support of the advocacy coalition in this effort to convince members of the Legislature not to allow the inherent discrimination of the traditional guardianship model in Bill 108 to be legally sanctioned. Please remember that what many people see as a last resort will be the first resort for the people about whom we are concerned, simply because of the extent of their disabilities.

In speaking to the justice committee earlier this year, OACL noted that the state has a duty to make the necessary legislative accommodation to the handicapping

effects of disability: The spirit of the law must be to lessen disadvantage. Although society is gradually recognizing and accepting this responsibility in relation to people with physical disabilities, ramps being only one of the many obvious examples, there is an apparent reluctance to recognize the social and legal barriers to equality faced by people with intellectual disabilities.

The handicapping effects of the traditional legal guardianship paradigm are particularly damaging to people with intellectual disabilities, a point that's already been made to the committee. Guardianship's discriminatory and unjust because it removes the fundamental right to self-determination, classifies and stigmatizes the person on the basis of disability, reduces his or her status to that of a legal non-person for all official purposes and offers no commensurate benefit in return. In fact, guardianship increases rather than reduces the person's vulnerability.

The Attorney General has told us that OACL helped his ministry to better understand the limitations and negative aspects of guardianship, but as many other organizations and individuals believed that guardianship was necessary, he said it would not be eliminated. Are those other organizations and individuals whose advice the government has apparently taken saying that it doesn't really matter that guardianship discriminates against people with severe intellectual disabilities or are they saying that they don't believe it? OACL and People First, whose members between them personally know more people with intellectual disabilities than any other organization in this province, believe it. It's a matter of fact and it's a matter of record.

The minister said he was looking for ways to "extend supportive, consensual decision-making" to respond to our concerns. OACL has been given to understand that the amendments related to powers of attorney for personal care represent the Attorney General's solution. With all due respect, OACL submits that the amendments do not remove the discriminatory and unjust effects of the proposed legislation.

The fundamental purpose is still substitute decision-making. In that model, a competent or capable decision-maker makes decisions for the person presumed to be determined to be incompetent or incapable. A process designed to legally replace a person in this way inherently jeopardizes people with severe intellectual disabilities. Replacement is not an equitable substitute for empowerment.

Third-party interests are legitimate and real. It's both unnecessary and morally repugnant to provide this security for professionals and other non-disabled persons at the expense of declaring people to be mentally incapable and assigning their decision-making rights to other persons. The same protection can be built into the consensual or supported decision-making model as it's presently built into the substitute decision-making model.

1530

OACL's concerns can't be addressed by loosening some of the rules in the traditional legal paradigm of guardianship, as these amendments do with respect to granting powers of attorney. Powers of attorney increase the empowerment only if people already exert control over their own lives. Powers of attorney, validated or unvalidated, are in



effect guardianship. They should be an option only for people who fully understand their implications.

The notion that powers of attorney don't have to be validated to be used for consent purposes, as the amendments imply, would be more convincing were the extensive provisions for validation to be removed from the act. The fact that there is a detailed validation process which includes assessment and declarations of incapacity will inevitably lead to the demand for validation by third parties to ensure the utmost protection the law can provide.

Although people wouldn't have to be further labelled by a finding of capacity, there is virtually no accountability in an unvalidated power. It would amount to unlicensed guardianship over the person.

When OACL suggested looking to powers of attorney as an avenue for change, it saw them as a way of stepping into a new and different paradigm. It saw some form of power of attorney as a potential vehicle for sanctioning partnerships in supportive decision-making. In this different way of thinking, there is no such legal fiction as incapacity or incompetency, since the necessary support is provided to enable people with intellectual disabilities, and others, to be regarded as capable of self-determination. That's the way it typically is for most of us. We're all free to accept support in our decision-making. We do so. We're never called upon to declare the extent of that support. That principle of presumption of capacity must be maintained for all people.

In its recommendation last February, the OACL outlined a broad framework for change in legislation related to decision-making and identified certain principles on which new legislation must be built if it's to be just and non-discriminatory. Rather than further disabling people whose decision-making capacity is already doubted on the basis of disability, the law must enable and empower them and protect their fundamental right to self-determination irrespective of the amount of support they require to exercise it. It's difficult to see how the provisions in sections 47 to 51 could accommodate a consensual or supportive decision-making model.

In part 1 of our brief, which I believe you all have, OACL explains again the implications of Bill 108 for people with severe intellectual disabilities and offers some suggestions for change. In part 2 we address the specific clauses that still cause concern and in part 3, at the invitation of senior officials of the government, OACL, with some assistance from its colleagues at the Canadian association, has tried to suggest some alternatives to powers of attorney. We believe these will be helpful not only to people who always need support in making decisions, but also to those of us who would really like to retain our natural status as presumed decision-makers in our own right, rather than eventually being replaced in the decision-making process at the very time we need the most support.

Rather than assessments of capacity, people must be enabled to identify the supportive decision-makers by whatever means they choose; by identifying them actually in writing, if that's possible, by indicating choice by any other means, or by demonstrating even the existence of a

trusting relationship with certain other people in which choices and wishes can be determined and interpreted.

Supportive decision-makers must be accountable. They must agree to act with utmost loyalty to the person in a manner that upholds that trust always. In documenting the acceptance of such responsibility, lawyers or other authorized persons must satisfy themselves of the legitimacy of the relationship and the absence of conflict.

Supportive decision-makers must adhere to strict standards of conduct in interpreting and communicating a person's wishes.

Consent for medical purposes must be deemed valid if either the person receiving the decision-making support or the person providing the decision-making support understands the nature of the process and the risks and benefits involved. The practitioner must take reasonable measures to confirm that the will of the person is being respected.

These alternatives are dignified, practical and possible. It's unacceptable in this day and age that new legislation would fail to address the critical issue of accommodation to the social and legal disadvantages of citizens with severe intellectual disabilities.

Not only the government of Ontario but all citizens of this province have an obligation to build the kinds of ramps that such people need. The Ontario Association for Community Living will do everything in its power to ensure that people with severe intellectual disabilities are not further disabled by legislation designed primarily to protect others. This is one of the most critical issues in which this association has ever been involved.

OACL and People First of Ontario are all willing to work with the government in developing just alternatives.

**The Vice-Chair (Mr Mark Morrow):** Any comments or questions?

**Mr Jim Wilson:** Thank you very much for your brief. I understand the points contained therein, but going back to a group we had earlier today, the Friends of Schizophrenics, in terms of guardianship, from my bantering back and forth with the parliamentary assistant to the Minister of Health, we're left in that situation where family members may feel it best, when their son or daughter is in a manic state, for example, to use guardianship and a provision that would be obtained through the courts to hospitalize a schizophrenic person in emergency situations. Do you have any comments on that? Under this model, as you correctly point out, this is another example where the only way, really, is to obtain a guardianship ahead of time.

**Mrs Cole:** Certainly I can't speak for parents of people with schizophrenia. I have no personal experience of that. I can say, as a parent of a person with a severe disability who has what we would officially call very limited typical means of making his wishes known but who can nevertheless make his wishes and choices known to people who know him very well—as a parent of a person with a disability, what I can say is that no matter what the particular concerns are of any one group, they should never be allowed to shape legislation that in the same process is going to deny the rights of a lot of other people who don't have



the same opportunity to speak and shape their own pieces of legislation. That's all I can say about that particular issue.

**Mr Tilson:** I have a question for Mr Walsh. It has to do with the powers of attorney legislation, Bill 108, and specifically section 13, which appears to deal with existing powers of attorney. One looks at all the powers of attorney that are now in existence, many of which do not have any witness. Some have one and don't have two, which is what this legislation requires. None of them that I can recall will have any specific statement that the witness is confirming the capacity of the person who's signing it.

Do you have any concern about whether section 13 or any of the other sections that perhaps I haven't noticed validate the thousands and thousands and thousands of existing powers of attorney that, in my view, may become invalid as a result of this bill? Do you have any concern on that subject?

1540

**Mr Walsh:** I'm not quite sure I understand your question, Mr Tilson. Is the concern that what we propose might have?

**Mr Tilson:** No. I guess I'm looking at you because you've indicated that you're a legal adviser. My concern is whether you have any concern on the validity of existing powers of attorney.

**Mr Walsh:** We really haven't a concern about that aspect of the legislation. We would have thought there would be some form of succession that would validate them.

**Mr Fram:** I'd like to take an opportunity to answer the question. Section 13 is a preservative section. It preserves all those powers of attorney that have been created since we amended the act in 1979 to bring in the Powers of Attorney Act. The Powers of Attorney Act provides for enduring powers of attorney.

What this does is to say that if you did a power of attorney that in effect was witnessed in accordance with the act, as it now is and has been, if it contains a provision that it will continue when the grantor becomes incapable, then it will be considered, despite the fact that it doesn't meet the formal requirements of this act, to be a power of attorney under this act.

**Ms Akande:** I'm interested in supported or supportive decision-makers. I see them as not necessarily being advocates as much as being support, but it can be a euphemism in many respects, can it not? If you look at the most dependent, those people who are most dependent in terms of their abilities, would not the support in fact be actually making the decision?

**Mrs Cole:** We've only looked at the people you described. We have never in any of our presentations raised any issues that affect people who can make their own wishes clearly known. Our sole effort in this respect has been to preserve the rights of the very people you have just described.

The issue is that because we don't know people with profound disabilities, we make assumptions about what they understand and how they make choices known. We make an incredible number of assumptions about that. I

can tell you as a fact, knowing a number of people with profound disabilities whom many people would just look at and assume that they would have no means of even having opinions or choices, that it's not a fact, that if we take enough care in getting to know people, to share their lives with them, rather than provide care for them, then we do begin to understand what they understand, how they communicate it, and we do learn to interpret that. That's what this is all about.

I think the Canadian association, which will appear before you on Thursday, will have much more detail on that, because it has an alternatives to guardianship task force that's had the opportunity of looking only at alternatives. They haven't been weighed down by the need to respond to legislation.

In the model of supported decision-making that is developing and is going to be ultimately accepted, I believe, by everybody, not just with respect to people with disabilities, all those guarantees of controlling or manipulating which you seem to be implying are going to be in—the idea is built on a trusting relationship that's got criteria which make it so that people will be held accountable if there's that kind of control or manipulation.

It's a question of building the legislation to do what we believe it ought to do rather than just doing what it's always done in the past. I don't have the kind of fears that I sense you're expressing, because I think legislation can be built to make those fears not fears at all. There just wouldn't be room for them. I really believe that.

**Mrs Sandys:** In our view, we would suggest that perhaps the term "guardian" is a bit of a euphemism, implying that it will protect the interests and wellbeing of people when in fact it will make them even more vulnerable than they currently are.

**Ms Akande:** My one concern, if I may extend this a moment longer, is that in fact there is a great deal of interpretation that is required by that person or persons who are giving support. Even with the very best intentions and respect for the individual's wishes, that interpretation would be necessary and would in fact allow one to make a decision which may rely more accurately on what they have inferred rather than what the actual person has implied.

**Mrs Sandys:** I think a supportive decision-making model challenges us to make decisions that are valid from the perspective of the person with the disability. If we don't challenge ourselves to do that and we rely on a substitute decision-making model, which is guardianship, then we're that much further behind. We haven't even challenged ourselves to do that.

**The Vice-Chair:** I want to thank you very much for that fine presentation.

#### ALLIANCE FOR LIFE

**The Vice-Chair:** Next we have Alliance for Life. Good afternoon. Just a reminder that you'll be allowed up to a half-hour for your presentation. We would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses.



As soon as you're comfortable, could you please identify yourselves for the record and then proceed.

**Mrs Jakki Jeffs:** Good afternoon. My name is Jakki Jeffs. I'm executive director for Alliance for Life—Ontario.

**Mrs Regina Weidinger:** I'm Regina Weidinger and I'm the executive board member for Alliance for Life across Canada, for the national office.

**Mrs Jeffs:** We're here today representing 80 educational pro-life groups and approximately 70,000 members in Ontario. Our concerns are in just two areas this afternoon and represent very much, I think, concerns of the ordinary folks. We can't profess to be professional doctors, lawyers or anything else, but these are some of the concerns we have which we would like this committee to address.

Subsections 10(2) and (4) of Bill 109: We're extremely concerned at the inference of these subsections. We understand that the presumption of these subsections is that a minor child from age 12 is capable under this act to consent to treatment without parental guidance, notification, input or consent. However, should the health practitioner find that a child of 12 or more is incapable with respect to the treatment, what is the procedure?: To notify a rights adviser. What about the parents of the child and their right to be involved in the medical treatment decisions for their children?

1550

Section 13: This section notes the right of a person of any age to apply to the board under section 26 to contest the finding of incapability or to refuse or give consent if the person is capable with respect to the treatment.

We would like to know if this section applies to children under the age of 12 and, if so, where are the rights of the parents to be part of this decision-making process? Will parents be forced to apply to be guardians of the person of their minor children under the Substitute Decisions Act, 1992, in order to protect their rights as parents concerning medical treatment for their children?

After our last presentation in March, a directive came into my possession. It was circulated by the Ontario Association of Sexual Health Professionals across this province. It noted Bill 109 especially, and subsections 8(1) and 8(2), and the fact that the bill included a section that has serious implications for health care services currently available to adolescents under the age of 16.

I quote in part subsection 8(2): "would effectively mean that physicians will refuse confidential treatment to those teens under 16 and thus deny those teens an aspect of care: confidentiality." Subsection 8(2) of the original proposed legislation stated: "A person who is less than 16 years of age is presumed to be incapable with respect to the treatment, but the presumption may be rebutted."

We note with regret that this section is not now a part of the amended proposed legislation.

In preparing for this afternoon, I have spoken with many of my friends and colleagues about the presumption of capability, which Bill 109 confers upon our minor children from age 12, should this legislation become law. Their reactions range from incredulity to anger at the audacity of legislators to take away their rights and duty as

parents to protect their children from making decisions which they are not capable of making.

In a report issued recently on Canadian families by Statistics Canada, it was noted that stable, husband-and-wife families made up a full 87% of Canada's 7,356,170 families in 1991. "The family is alive and well with 86% of Canadian children under 15 living in two-parent families," reports Gordon Priest, Statistics Canada's social data expert.

With statistics such as these which show that 86% of Canadian children 15 and under live with and are cared for by their parents, how dare legislators have the audacity to undermine the rights of Ontario parents to speak for their minor children in health matters?

The key word, it would seem, in all this was mentioned in the Ontario Association of Sexual Health Professionals' comments: confidentiality. Under the original proposed legislation, it would no longer have been possible to refer minors for abortion through school-based teen health clinics or to prescribe oral contraceptives to minors or conduct internal examinations of minor children without consulting, informing or receiving the parents' consent.

Under the current proposal, this practice, it appears, will be allowed to continue sanctioned by law, with the addition that minors can be admitted to hospital for their abortion or other treatments. In the past, the minors have been sent to abortion facilities because they did not require parental consent, which the hospitals did require.

I have spoken to doctors in my local area and one of their concerns has been the fact that these so-called "teen clinics" have not been requested to inform either the parents or the family physician that the minor child has had an abortion or is now using oral contraceptives. As any physician understands, it's extremely important to know the medical history when dealing with patients.

We remain utterly opposed to these sections which appear to exclude parents from medical treatment decisions for their minor children to which, as parents, they have every right to consent.

We respectfully request that this committee uphold the rights of Ontario parents to give consent to medical procedures for their minor children. At the least, parents should be notified when their children are considering medical treatment, whether it be prescribed in a hospital teen health clinic or a doctor's office.

Our comments to Bill 109 and Bill 108 are focused in the background information of the Substitute Decisions Act. Section 9, entitled "What are the Key Features of the Substitute Decisions Act," reads: "The right to instruct a designate with respect to future treatment and care, and the right to have those wishes respected under the power of attorney. The Substitute Decisions Act, together with the Consent to Treatment Act, ensure that a person's 'living will' is respected."

We understand that nowadays people are concerned that their last days will be fraught with pain and suffering and spent hooked up to modern technology. We realize that this legislation seeks to achieve the self-determination of the patient over his or her own fate in the face of a potentially abusive use of technology. However, this legislation



will be the first legal recognition in Ontario of a document called the living will.

Our concern with the concept of legalizing living wills stems from the knowledge that at present, patients, family and physicians are free to exercise their choices and responsibilities without legislation, and the possibility of legal action in these areas is more imagined than real. Legislation cannot resolve conflicts arising from questions regarding medical competence or the accuracy of a prognosis any more than it can guarantee that the patient's wishes will be accurately interpreted. The doctor is the servant of the patient, and we are concerned that this legislation will make the doctor a servant of the legislation and undermine his ability to be an advocate for his patient.

Consider the patient who has no living will. If the doctor is forced to serve the statute, he or she may refuse to withhold or withdraw artificial life-sustainers from dying patients. Most important, how is it possible for a person to make intelligent, informed decisions regarding specific and appropriate responses to unknown events and detailed circumstances?

We understand and applaud the intentions of these bills to protect patients' rights, but our opposition to them stems from that very same need to protect patient rights. Without the complication of law, the patient already has the right to refuse, either through family or legal guardian, the use of extraordinary life-sustaining procedures. An immediate conclusion that one may make from this legislation is that the only way in which a person's inherent right may be exercised is through a living will, and this just is not so.

We are concerned that it is deemed necessary to enact laws to ensure patient rights, since this, once again, would appear to infer that without this legislation we are at the mercy of our doctors. We object vehemently to the inference in this legislation that doctors are masters of their patients, not servants. We believe that any legislation that appears to make it necessary to write a living will in order to avoid unreasonable treatment during the dying process is undercutting patients' rights.

We see as a consequence of this legislation the abandonment of the right which we all have to refuse to be treated by any or all physicians. In the United States, where the concept of the living will is enshrined in law, there is a growing belief that the only way to avoid overtreatment is to have a living will and that this legislation enshrines your right, not recognizes it as inherent.

It is our belief that living wills tend to exclude family from decisions and responsibility. This is a negative factor since only the family would have had the opportunity or the love to take the time to talk with the person and determine how they feel about certain courses of action in given circumstances.

In this, as in most other living will legislation, there is no penalty attached for violation. To underresuscitate a patient with a living will may lead to his death, but there is no avenue for action since the living will is directed to overtreatment.

This legislation purports to protect doctors, yet doctors have always had the right to withdraw from a case if they

are asked to perform acts that are incompatible with their conscience as physicians or individuals.

We suggest that if it were really the case that patients are unable to extract themselves from doctors who would overtreat them, if it were really the case that doctors are not free to withhold or withdraw certain procedures which they deem useless to the patient for fear of criminal prosecution, then legislation could be written that simply states that when a patient suffers from a fatal disease, a physician can register the fact with an appropriate hospital body that would have the right but not the duty to verify the fact. A mentally competent patient could then request in writing that no extraordinary treatment be applied to him or her. Where a patient was incompetent to act, by age or condition, the family could make a similar request.

#### 1600

Once the written request had been made, the legislation could stipulate that the treating physician was not subject to civil or criminal prosecution for omitting or ceasing treatment. In those cases where a physician is concerned that the family is not making decisions based on the best interests of the patient, he could have recourse to the courts to place the patient under guardianship.

In summary, our opposition to legislation which will legalize living wills is based, in our belief, that it undermines the rights already inherent to each person. In the United States there have been several initiatives which have endeavoured to expand living will legislation to "aid in dying," a euphemistic term for a lethal injection.

In 1989 in a model aid-to-dying act, which was drafted by the University of Iowa college of law, the commentary to the model law explains, "Minors have the right to request aid in dying whether or not their parents agree." In the model law, aid in dying was defined to include "the administration of a qualified drug for the purpose of inducing death." The model law also recognizes the need to provide euthanasia to those unable to request it and goes as far as to state that, "It is not improper for a governmental agency or health care provider to suggest to a patient's family that they request aid in dying." Cost containment also plays a vital role in this proposal. A preamble to an earlier draft of the act stated, "Effectively, this act provides for quality control in the termination of life," and it "provides a principled means of managing our health care resources."

Those who support euthanasia consider legislation which gives force of law to living wills as the first step to decriminalizing euthanasia and assisted suicide. We vehemently oppose this legislation on the basis that it provides that first step and agree with Harry van Bommel's own conclusion which he states in a book entitled *Dying for Care—Hospice Care or Euthanasia*: "The key, however, remains the desperate needs of people who have terminal or life-threatening illness. If we are not willing, personally, to provide the loving support of hospice care to people who are dying, then we cannot delegate our human responsibility to these people with a euthanasia law that will allow others to kill them."

This brief is respectfully submitted. Thank you.

**The Chair:** Thank you. Questions and comments.



**Mr Owens:** I guess, to put it diplomatically, I'm at variance with some of the comments you've made in your brief. In terms of the issue with respect to living wills, a person's death is a very individual experience and it's my view that he or she should be the person dictating the events and perhaps the time at which death takes place.

It's my experience through volunteer work with terminally ill patients that this is an event that often requires some careful planning, some careful thought, and I think your comments that simply legalizing a process where a person can plan through a living will the treatment process is an opening for euthanasia—I have to disagree with you strongly on that. I think the reasons people wouldn't want to draw up living wills is to give comfort to those who care for them.

It's been my experience with the group I was dealing with, that in fact you reflect that people who love them should have an opportunity to participate in this decision. It's been my experience at that point that those people who "love them" have been nowhere to be found, that as the patient drew near to death, the individuals who were supposed to be closest to them at that point were not there.

Again, it's my view that death with dignity through the process of the living will, through the conscious desire of a patient to choose the types and the level of treatment that he or she receives is his or her right. It clearly does not open the door to euthanasia, as you've described.

I think the draft piece of legislation coming out of Iowa—we clearly have two different medical systems between Canada and the United States and it's our view that we have a system that endeavours to preserve dignity and it's not a system that looks at living wills or death with dignity as a means to rationalize health care or to put some kind of economic order into the process.

It has been suggested by some groups that you go out and you talk to patients who are dying, talk to them about their experiences, talk to the families, talk to the physicians who are involved in palliative care situations. I think that your views would hopefully be swayed by the human experience rather than perhaps an intellectual decision that you've made.

**The Chair:** Any response?

**Mrs Jeffs:** Yes, I'd like to. You're assuming, then, I have no human experience at all of it. We come from families, just as you do. Our reports on the fact that living will legislation has indeed been seen by those who propose

and agree with euthanasia as the first step is not something that we have just picked out of an intellectual hat, and that brief was put together from a human area because I don't have medical or legal expertise; it's looking at it.

I sat with my father while he died. I know the last stages of death. The people whom we represent have had disabled family members die, have had horrible situations in death. What I'm saying and what we are saying is that we cannot for sure stipulate the minute-by-minute, blow-by-blow decision of our death experience because we don't know it. There is no problem if people feel comfortable writing a living will, fine; but we do not need to give that living will force of law. We do not need to legalize it or we may find our doctors unable to help in situations 10 years down the road, when the care that was foreseen when the living will was written was maybe extraordinary, but 10 years down the road it wasn't. Yes, I believe you're absolutely right that we should be able to determine what we want and what we don't in those procedures, but not under the auspices of a living will.

**Mr Owens:** I think, though, that in terms of reviewing living wills, perhaps, whether it's through a regulatory process or through discussion, there needs to be some level of re-evaluation of a patient's wishes. But, again, it's been my experience, through personal family experience, through the volunteer work that I have engaged in, that it's very difficult. While the do-not-resuscitate order has been in place for not a great deal of time, it's been around. Whether people choose to admit that it's there or not, it's there. In order to ensure that the patient's wishes are clearly understood and reflected in the treatment, I think that this issue clearly needs to be codified. I think, for reasons, perhaps, that you've stated, that the physician will know where he or she stands with respect to the wishes of the patient. If you want to look at it from that perspective, perhaps that would give you comfort.

**Mrs Jeffs:** It doesn't.

**The Chair:** Further questions or comments? Seeing none, Mrs Jeffs and Mrs Weidinger, on behalf of this committee I'd like to thank you for taking the time out this afternoon to give us your presentation.

This committee now stands adjourned until 9:30 tomorrow morning.

The committee adjourned at 1611.



**Also taking part / Autres participants et participantes:**

Fram, Steve, counsel, policy development division, Ministry of the Attorney General

Malkowski, Gary, parliamentary assistant to the Minister of Citizenship

Valentine, Mary Beth, senior policy and program adviser, Office of Disability Issues, Ministry of Citizenship

**Clerk / Greffière:** Freedman, Lisa

**Staff / Personnel:** Swift, Susan, research officer, Legislative Research Service











## CONTENTS

Tuesday 11 August 1992

<b>Advocacy Act, 1992, and companion legislation</b> . . . . .	J-159
Ad Hoc Committee on the Advocacy Act, Substitute Decisions Act and Consent to Treatment Act . . . . .	J-159
John Ellis, executive director, Alzheimer Association of Ontario	
Elsie Etchen, president, Ontario Friends of Schizophrenics	
Ms Barbara LeBlanc, manager, health policy, Ontario Medical Association	
Patty Simpson, policy analyst	
Deborah Wall-Armstrong, board member, Ontario Nursing Home Association	
<b>York Support Services Network</b> . . . . .	J-163
Karen Hirstwood, program manager, York region, north	
Penny Hubbert, board president	
<b>Ontario Friends of Schizophrenics</b> . . . . .	J-168
June Beeby, executive director	
Elsie Etchen, president	
<b>Campaign Life Coalition Ontario</b> . . . . .	J-173
Clare Dodds	
Kurt Gayle	
<b>Ontario Association of Children's and Youth Institutions</b> . . . . .	J-177
Claire Braseliten, executive director	
Julie Ann Wolfe, volunteer board member	
<b>Ontario Association of Residences for Troubled Youth</b> . . . . .	J-177
Andrea Rifkin, board secretary-treasurer	
Gita Schwartz, executive director	
<b>Ontario Association for Community Living</b> . . . . .	J-182
Audrey Cole, chair, committee on advocacy and guardianship	
Cheryl Easton, president	
Judith Sandys	
Rod Walsh, legal counsel	
<b>Alliance for Life</b> . . . . .	J-184
Jakki Jeffs, Ontario executive director	
Regina Weidinger, national executive board member	

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- \*Cordiano, Joseph (Lawrence L) for Mr Mahoney
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- \*Sullivan, Barbara (Halton Centre L) for Mr Chiarelli
- \*Tilson, David (Dufferin-Peel PC) for Mr Harnick
- \*White, Drummond (Durham Centre ND) for Ms Carter
- \*Wilson, Jim (Simcoe West/-Ouest PC) for Mr Runciman

\*In attendance / présents



## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Wednesday 12 August 1992

### Standing committee on administration of justice

Advocacy Act, 1992,  
and companion legislation

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Mercredi 12 août 1992

### Comité permanent de l'administration de la justice

Loi de 1992 sur l'intervention  
et les projets de loi  
qui l'accompagnent

Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
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### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

### **Index inquiries**

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7410 or 325-7411.

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### **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Wednesday 12 August 1992

The committee met at 0945 in committee room 1.

### ADVOCACY ACT, 1992, AND COMPANION LEGISLATION LOI DE 1992 SUR L'INTERVENTION ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervenants en faveur des personnes vulnérables; Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne; Bill 109, An Act respecting Consent to Treatment / Loi concernant le consentement au traitement; and Bill 110, An Act to amend certain Statutes of Ontario consequent upon the enactment of the Consent to Treatment Act, 1992 and the Substitute Decisions Act, 1992 / Loi modifiant certaines lois de l'Ontario par suite de l'adoption de la Loi de 1992 sur le consentement au traitement et de la Loi de 1992 sur la prise de décisions au nom d'autrui.

### ONTARIO ASSOCIATION OF CHILDREN'S MENTAL HEALTH CENTRES

**The Chair (Mr Mike Cooper):** I'd like to call this meeting of the standing committee on administration of justice to order. We'll be continuing with the second round of public hearings on the amendments to the advocacy package.

I'd like to call forward our first presenters, from the Ontario Association of Children's Mental Health Centres. Good morning. Just as a reminder, you'll be allowed a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Dr Xavier Plaus:** Good morning. I'm Dr Xavier Plaus. I'm a psychologist and the executive director of the Robert Smart Centre in Ottawa, which is a children's mental health centre providing children's mental health services to adolescents.

**Ms Suzanne Stamper:** I'm Suzanne Stamper. I'm the assistant director of the Ontario Association of Children's Mental Health Centres, an umbrella organization representing 87 children's mental health centres in the province of Ontario.

**Dr Plaus:** The Ontario Association of Children's Mental Health Centres appreciates the opportunity to make this presentation to the standing committee on administration

of justice. Our request for permission to attend at this committee was prompted by a consultation meeting for a variety of service providers on June 2, 1992. At that time, we were apprised of a very significant change in Bill 109 and collateral changes in Bill 110. More specifically, we are referencing the decision, after first reading, to drop from the bill section 8, which stated, "A person who is less than 16 years of age is presumed to be incapable with respect to the treatment, but the presumption may be rebutted."

Since that consultation meeting, the association has had time to consider in some detail the implications for the children we serve, their families and member centres. There are two basic issues raised by the proposed amendments that we wish to bring to your attention. On the one hand, there is the basic conflict between parental rights and the child's rights and, on the other, the concept of consent as it relates to the parent-child relationship. In the context of the first issue, the association supports the retention of section 8 in Bill 109. On the second, it will be made clear that the concept of capacity is too complex to be settled by a one-sided presumption of capacity over a presumption of incapacity that is totally silent on the impact of age.

The Ontario Association of Children's Mental Health Centres, as we mentioned, represents 87 treatment centres across Ontario. These centres provide a range of multidisciplinary treatment and prevention programs to children with emotional problems and their families. The association's mission is to advocate for the wellbeing of children and families, to promote an environment conducive to positive mental health for children and families and to support, promote and maintain quality children's mental health programs throughout Ontario.

The extension of freedoms and legal privileges to children and adolescents is a controversial topic in our society. Finding a balance between the competing interests of individual freedoms for children and maintenance of family autonomy and integrity is fraught with considerable difficulties. The problem arises most acutely when mentally ill children seek to exercise their right to autonomy, while sometimes acting destructively towards themselves or others, disrupting family life and ignoring those who believe they are acting beneficially on their behalf.

The perceived benefits on the side of granting children autonomy are that they may be more likely to seek treatment for socially stigmatizing health concerns if such treatment could be outside of parental involvement or awareness, that there is mounting evidence that granting them more control over treatment decisions may enhance the participation and encourage the development of self-efficacy and that expecting more autonomy and responsibility may provide requisite experience for responsible decision-making later in life.



At the same time, endowing children with greater freedoms in decision-making may be detrimental, by overwhelming their ability to consent and inducing stress and anxiety, and undermining the authority of parents, leading to family discord and compromising family integrity.

The debate on the right to self-determination in treatment decisions is hinged on whether young people are capable of providing valid informed consent. However, it must be pointed out that much of the debate is focused on physical health decisions and especially reproductive health decisions. This association's particular focus is on that subset of children and youth who are emotionally disturbed and who, by the very nature of their disorder, are frequently unwilling to participate over time in any treatment process.

In this presentation, the association wishes to speak to a number of issues that arise from Bill 109, other statutes and proposed bills.

The role of the family: In Ontario, the statute that bears most directly on the issues at hand is the Child and Family Services Act. This is also the statute that governs the operation of children's mental health centres in the province.

The first section of this statute clearly delineates a set of principles which articulate the purposes of the act. The most relevant are, and I'm sure you know them: to promote the best interests, protection and wellbeing of children; autonomy and integrity of the family unit; the least restrictive or disruptive course of action; that children's services are to respect the children's needs for continuity of care and to take into account physical and mental developmental differences among children.

The association is gravely concerned that Bill 109, if passed in its current form, will undermine the legitimate parental right and responsibility to act in the best interests of the child, aggravate relations between parent and child and force responsible parents and health practitioners into an adversarial relationship with the child.

Generally speaking, the law recognizes the right of parents to the care and custody of their children. In addition, criminal law provides that parents or persons in loco parentis are required to provide the necessities of life for children under the age of 16 years.

Similarly, in law parents are presumed to be the natural personal guardians of their children. To maintain this stewardship, however, they must act in the best interests of their children. The CFSA delineates in considerable detail when a child is in need of protection.

We wish to point out several sections of the CFSA where the authority of parents over children under 16 is recognized in statute. For example:

"A service provider may provide a residential service to a child who is less than 16 years of age only with the consent of the child's parent or, where the child is in a society's lawful custody, the society's consent, except where this act provides otherwise."

Similarly, the statute provides that, for a child under 16: On information provided by a parent, a justice of the peace may issue a warrant to apprehend a runaway child; a service provider may administer a psychotropic drug on parental consent; an application may be made to a court

for commitment to secure treatment on parental consent; an application may be made to an administrator for emergency admission to secure treatment on parental consent.

Under these last two examples, the child's consent to admission to a secure treatment program is not required. However, under Bill 109 as it is proposed, treatment by a health practitioner would not be permitted during the period the child is in a locked residence, unless he or she consents. However, treatment by a non-health practitioner, for example a social worker, would be permitted.

In a similar vein, Bill 108 speaks to the issue of care in subsection 2(2). It states: "A person who is 16 years of age or more is presumed to be capable of giving or refusing consent in connection with his or her own personal care."

This is further complicated by sections 44 and 46 of the same bill. These sections define when a person is incapable of personal care. However, the combination of subsection 2(2) and sections 44 and 46 seem to make it not possible for a person under 16 to sign a power of attorney for personal care. It appears this may create a situation where 14-year-olds under the CTA or Bill 109 could consent to complicated surgery, if not found incapable, but could not sign a power of attorney directing someone else to make a decision with respect to their clothing if they thought they were going to be incapacitated as a result of the surgery.

It is obvious from these examples that the situation is not straightforward, but that for children under 16 years of age, the authority of parents for the care and treatment of their children is given some recognition in statute.

The CFSA does recognize two limitations to this authority. The first is in regard to counselling. Section 28 states:

"A service provider may provide a counselling service to a child who is 12 years of age or older with the child's consent, and no other person's consent is required, but if the child is less than 16 years of age the service provider shall discuss with the child at the earliest appropriate opportunity the desirability of involving the child's parent."

The CFSA further provides that a residential placement and advisory committee shall review the placement when the child objects and a child over 12 may apply to the Child and Family Services Review Board for a determination of where he or she should remain or be placed.

With these perspectives in mind, the OACMHC strongly endorses this support for parental rights and responsibilities in the care and treatment of their children. Further, the OACMHC strongly endorses the retention of age 16 as the age of consent, but the presumption of the lack of capacity may be rebutted on application.

This leads us to examine the question of capacity to consent as it is influenced by the parent-child relationship.

The child's decisional capacity: The principal components of informed consent are that the consent must be informed, that is, made knowingly; competent, that is, if there's a capacity to make it intelligently, and voluntary. It's the latter two which are the foci of our concern. The question of capacity, voluntariness and the effect of a capacity ruling will be dealt with in turn.



First, capacity: The research on psychological abilities of children suggests that by the age of 14 a child's comprehension of treatment would be at the same level of reasoning as that of an adult. Thus, if reasoning ability alone is the guide, children over the age of 14 are likely to be as capable as the average adult.

However, some research also suggests that adolescence is when the child is coming to terms with individuation and separation. The result is conflict with authority figures—parents—and susceptibility to peer pressure. This raises the question of whether capacity is merely a function of reasoning capability or whether other psychological factors should be considered.

It is clear that a child's wishes are not coextensive with his or her best interests. The question arises, "At what point in a child's development should parents be permitted or, worse, be forced to withdraw from any participation in a child's treatment?"

An example of this occurs in the Young Offenders Act. This federal statute provides for decisional capacity by age 12, such that no order can be made unless the youth court has secured the consent of the young person. However, the giving of consent to treatment under this section is very rare, thus rendering the section effectively useless.

This result should not be surprising. For many disturbed young people, the very nature of their problems precludes them from providing consent. Children's mental health centres are very familiar with young people initially objecting to a treatment intervention but over time becoming a willing participant. This is most particularly the case in residential care. Adolescents typically arrive resistant, but in the context of a very structured program come to feel safe and secure and thus available for psychosocial intervention and treatment.

It seems clear that giving a child who is depressed, disturbed or angry the right to consent is more harmful to the child and family and more costly to society. With hostile and oppositional youth, not providing treatment results in several typical courses of events: Family functioning is impaired, the young person ends up on the street at considerable risk to him or herself, or a pattern of criminal behaviour develops, frequently resulting in incarceration.

The third component of informed consent is voluntariness. Research on this topic suggests that adolescents making treatment decisions are responsive to parental influence and generally deferent rather than reactant to parental authority. An excellent research study asked adolescents their reasons for deferring to parental authority. They tended to give four types of responses: They felt coerced, or had no choice; they wished to avoid family tension and conflict with parents; they respected parental judgement and felt their parents knew more about such matters, and they felt a need for parental support, emotionally and financially.

From this kind of research finding, there is no conclusive evidence that adolescents are incapable of voluntary consent. However, there is a suggestion that there are important differences in the quality of decision-making autonomy between adolescents and young adults.

In a recent unreported decision in June this year, the Supreme Court of Canada considered the nature of an

interpersonal relationship and its impact on the capacity for consent as follows:

"The concept of consent as it operates in tort law is based on a presumption of individual autonomy and free will. It is presumed that the individual has freedom to consent or not to consent. This presumption, however, is untenable in certain circumstances. A position of relative weakness can, in some circumstances, interfere with the freedom of a person's will. Our notion of consent must, therefore, be modified to appreciate the power relationship between the parties."

Although the case before them dealt with sexual activity between a physician and patient, they drew the analogy to the parent-child relationship and others where an underlying personal or professional association creates a significant power imbalance between the parties. The court held that the mere existence of such a power dependency relationship will usually be evidence of an inequality of power such that the weaker party will not be in a position to choose freely.

Finally, it is our contention that when capacity is being considered in regard to an individual under the age of 16, two other criteria should be considered, namely, the psychological development of the child and maturity or life experience.

In a 1982 article entitled "Competence: No Longer All or None," Gaylin argued that when a person is very old, or perhaps lacking a little competence, there is a reason to allow the person to, for example, choose not to have life-saving medical treatment. The reason is out of respect for who the person is and has become, whereas "We may deprive young people of certain privileges of autonomy out of respect for the person he might become, and out of fear that his own vision of the future may be too limited to allow even himself a proper respect for its value."

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When these considerations are taken in total, it appears that:

(a) There is considerable reason to believe the average younger, normal adolescent will be sufficiently influenced by the power dependency relationship with parents as to not be in the position to choose freely;

(b) There is a subset of adolescents who will demonstrate sufficient psychological independence as to be viewed as "emancipated," but will remain under the statutory control of their parents if they remain in the parental home while under 16;

(c) There is a further subset of adolescents who, because of emotional disorders, may possess the intellectual capacity to consent but be deficient in psychological development, maturity or life experience.

It seems important, at this point in time, to acknowledge that there's no legal formula that can be applied across all contexts. However, as one approach to a differential response, the OACMHC recommends that subsequent regulations under Bill 109 require the health practitioner to consider the psychological development of the child and maturity of life experience when considering the question of capacity.

Effect of a capacity ruling: Mandating that a health practitioner must make a capacity judgement for an



adolescent under 16 has two types of negative consequences when the decision is for incapacity. These consequences can be psychological or procedural.

The psychological consequences for the child are as follows: (1) a labelling effect, being destructive to the adolescent's self-esteem; (2) a negative impact on the relationship with parents and health practitioners, and (3) an intensification of an adolescent's feelings of loss of control.

From a procedural point of view, we have two concerns. First, on the one hand, if a child over 12 is found not to have capacity, a rights adviser is informed. This is an inappropriate intrusion of the state in the parental role and responsibility. In addition, there's no way for a parent or a children's aid society to make an application to the Consent and Capacity Review Board to challenge a health practitioner's decision that a child is capable.

Second, for emergency admissions to secure treatment, there would be two regulatory bodies to which a child could appeal, the Child and Family Services Review Board and the Consent and Capacity Review Board. The OACMHC supports prior recommendations that a mechanism be established for cross-appointing members to both the Child and Family Services Review Board and the Consent and Capacity Review Board, such that the evidence can apply to both issues of committal and capacity.

Issue 3, the nature of treatment: Bill 109 at subsection 6(2) recognizes, "A person may be capable with respect to some treatments and incapable with respect to others."

As a corollary, children are capable of different decisions at different ages. The concerns that underline much of the conflict on this issue result from the type of treatment that is being envisaged. Thus, some have argued before this committee that the reference to age 16 would result in adolescents being refused or failing to seek needed health services. It is this association's contention that leaving open-ended the issue of age of consent will have the same effect; that is, some adolescents, because of the nature of the mental disorder, will refuse treatment, to the detriment of their long-term wellbeing.

Consent to treatment must be looked at differentially depending on the type of treatment involved. Those professionals supporting an extension of children's rights frequently are doing so in the context of physical health, particularly around consent to abortion, contraception and treatment of sexually transmitted diseases.

When an adolescent is asked to consent to an abortion, this is a single event in time. The evidence to date would argue that the majority of children 14 years of age and older possess the adult capacity to consent as you have defined it. What is being advocated is the child's right to seek such treatment either against parental wishes or without their involvement.

In most treatment areas, and for the majority of adolescents, either there will be no disagreement or the young person will go along with parental wishes, but there are circumstances when an independent source of action is in the child's best interests and when legislation should make this possible.

Our association fully agrees with this perspective. However, it is our contention that mental health services

perforce must be handled differentially from other health concerns. Treatment services that form the core of children's mental health centre interventions with adolescents mean that consent is not a simple binary function. Rather, it is a shaping process over time by which and through which the adolescent's participation is elicited, prompted or pressured.

The major ethical and therapeutic issue in psychosocial intervention is how to accomplish pressuring for change, not in a punitive manner but in a caring and supportive atmosphere. By attempting to deal with one health problem for a particular subset of adolescents, you have created a very grave one for a different subset of adolescents and their families.

Given that one legal mechanism cannot cover all treatment contexts, the association further recommends that a logical exemption be made regarding consent to treatment and that the following clause be added to Bill 109:

"A child between the age of 14 and 16 is presumed capable to consent to an abortion or contraceptive medication but this presumption of capacity is rebuttable on application."

The association recognizes that there are potentially other areas where conflict between parent and child may arise as, for example, in kidney donation between siblings. However, in Ontario legal mechanisms are in place—the Child and Family Services Act and proposed Bill 109—to handle such events.

Our recommendations then are that the association:

Strongly endorses the support of parental rights and responsibilities in the care and treatment of children;

Strongly endorses the retention of age 16 as the age of consent, but the presumption of lack of capacity may be rebutted on application;

Recommends that the subsequent regulations under Bill 109 require the health practitioner to consider the psychological development of the child and maturity or life experience when considering the question of capacity;

Suggests that a mechanism be established for cross-appointing members to both the Child and Family Services Review Board and the Consent and Capacity Review Board such that the evidence can apply to both issues of committal and capacity; and

Recommends that the following be added as subsection 8(3):

"That a child between the ages of 14 and 16 is presumed capable to consent to abortion or contraceptive medication but that this presumption is rebuttable."

Conclusion: The focus of this association's concern is that Bill 109 avoids the complex issue of child and adolescent consent by opting for an extreme solution. By remaining silent on the issue of age, great harm will be done to family integrity and mental health services for those children most in need of intervention.

One fundamental issue raised is how society should resolve the primary moral conflict between self-determination and responsible parenting. The second issue is that the question of capacity to consent is too complex to be resolved by a sweeping assumption of capacity. It is readily apparent that some middle ground must be achieved.



The association wishes the Legislature of this province to recognize that a one-sided solution to these dilemmas does not make for good law, that there's no legal mechanism that can adequately deal with all contexts involving the treatment of children, and that previous legislative efforts, particularly the CFSA, have been framed in the general context of supporting, not abrogating, family rights and responsibilities and this direction must be continued in the best interests of all.

**The Chair:** We have time for a quick question from each of the caucuses.

**Mrs Barbara Sullivan (Halton Centre):** This has been a useful brief to us. As you will know from the second round of public hearings, we have been placing a fair amount of concentration on the issue of age.

As I reread the Child and Family Services Act and the obligations that are placed there, I'd like your opinion—and I don't know that we've pursued this with any other groups because we're trying to come to terms with the issue ourselves—as to whether the Bill 109 definition of capacity, "A person who is capable with respect to a treatment is able to understand the information that is relevant to making a decision concerning the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision," isn't where the problem is, rather than age itself, and that determining capacity with a young person may require different criteria than determining capacity with an adult.

**Dr Plaus:** I think the definition of "capacity," as you've defined it in Bill 109, really comes at it from the perspective of adults, so that the components of what is implied in the question of capacity changes if you look at it from the perspective of development over time and the child's capacity to understand the information and be informed.

For example, if you inform adolescents of their rights when they first enter a residence, they are so anxious that they may say they understand and agree, but if you ask them a few days later what their rights are, they haven't a clue. They didn't hear you. So there's a problem with getting the information. I then suggest there's a problem with understanding it not solely intellectually, but in terms of framing it in terms of what is going to happen to their lives over the next few years.

You can talk to a 14-year-old girl about the effects of prostitution, but it has no meaning to her in terms of where her life is going to end up because it doesn't have any significance. What is more crucial at the moment is that she is going to be able to buy a really nice wardrobe.

**Mrs Sullivan:** I think the capacity decisions are being made within the context of medical treatment. As I look, by example, at the professional's determination of "capacity" of a person who may be distraught, emotionally overwrought, who may have a mental handicap, in those circumstances the health practitioner would say that this young person lacks capacity to make a decision, and the substitute decision-maker, who is the appropriate substitute decision-maker under this or another bill, should be

consulted in terms of providing consent to the medical treatment.

**Dr Plaus:** Historically, it was a major advance when mental health was conceived within the same philosophical framework as health problems. But I think we're beyond that now. We understand that when we're talking about mental health services, when you apply the same rubric as you're applying for medical problems, you're missing some of the issues of the kind of participation the adolescent is expected to have in arriving at the willingness to participate, for example.

For me, a good contrast is in asking a 15-year-old whether she wants to have an abortion, because then it is like a light switch; the consent is a binary yes or no. But when you're talking about involvement in a treatment process that's going to go on over a long period of time, getting an adolescent to consent to that is a crucial part of the treatment itself, because you're asking the adolescent to participate in growth and change. So the concepts of health as they apply to medical disease issues are not the same issues in terms of consent when we're talking about psychosocial or mental health problems for adolescents.

1010

**Mr Norman W. Sterling (Carleton):** First of all, I really appreciate your brief. You've done a lot of work on it.

**Dr Plaus:** Thank you.

**Mr Sterling:** It's very well done, of very high quality.

Can you tell me, if there was not the rights adviser involved, as indicated by this legislation, would you be here today?

**Dr Plaus:** Yes, probably. The rights adviser has added one slice of it in terms of what it does, in our view, to what is the role of parents. But at the same time, when we saw the initial version with the presumption of lack of capacity at 16, that was great. We run into problems all the time trying to treat 16- and 17-year-olds who we don't believe understand what the consequences are going to be, but I think many professionals in the mental health business said, "Okay, at least parental authority is still there for kids under 16."

But when we saw the amendment, the whole group of service providers at that meeting in June blew off the roof, because everybody got very upset that in our perception the drafters of the bill didn't understand the question of capacity as it relates to 12 to 16. So there are two issues. The rights adviser is one component of it, but there's also the issue of understanding the complexity of what is around the question of capacity when we're talking about a developing person, not an adult.

**Mr Sterling:** Your anger was not so much with regard to what is going to happen in the future, but the lack of understanding about what capacity meant in terms of mental health.

**Dr Plaus:** But our expectation is that if it was passed the way it is now, we would not be able to treat kids between 12 and 16 until things had gotten so out of control that the parents were going to withdraw their statutory



rights to care for the kids and kick them out of the home. They'd end up in the care of the children's aid society or they'd be on the street and breaking the law and end up on an open custody order.

Our view is that what you're doing is preventing us from dealing with those kinds of adolescents until the problem becomes so severe that the intervention has to be mandated by law, rather than empowering the parents to say, "Look, we need assistance for our kids who are in trouble," and to seek it voluntarily.

**Mr Stephen Owens (Scarborough Centre):** Just in terms of your concerns with respect to age, I don't think there's clearly the magic age where all of sudden a person develops reason. I think that our legislation, in terms of having the treatment agency or physician or perhaps a worker from your agency determine capacity, is probably a more reliable test as to whether the individual understands the information, and probably more importantly, understands the consequence of either the refusal or the acceptance of the treatment. That's a situation or a language that allows situational analysis to take place, as opposed to having the magic age, whether it's 12, whether it's 16, whether it's 21, in place.

The second point is with respect to your concerns about the family involvement. I think that especially in agencies such as yours, as to the nature of the problem that children have who come to your services, be it physical abuse, sexual abuse, I have a real difficult time trying to put it in blanket language that would say, "Yes, all parents need to be involved in all situations with respect to the treatment of their kids," especially children who are coming from dysfunctional living situations.

**Dr Plaus:** On the face of it, that makes obvious sense, except if you are not aware of the fact that in many adolescent treatment centres, even if the adolescent has been physically or sexually abused, he or she will return home. If they've been taken out of the home and the care of their families before they're 16, they will go back when they're 16 or 17. The majority of our kids, in point of fact, end up, under some rubric or other, returning home.

My perspective on that is that if they're going to continue to be involved with their families, no matter how destructive the family is, treatment professionals need to continue to try to help the adolescents and their parents work together in some way that's going to benefit the adolescents and the families in the long run.

You can't just assume that because the child is in need of protection you're going to take the kid out of the family and the family's destructive influence is going to be, therefore, wiped out. It doesn't happen that way.

**Mr Owens:** No, and I think that would be a naïve presumption, to think that would happen. But in terms of the child, to individually assess him, let's take a look at a child coming from that situation. I raised the same view with the children's aid society, that you have a child who is coming out of a coercive situation, whether it's physical abuse or sexual abuse. My question is, why would you want to put them into yet another coercive situation where

they're not being allowed to determine for themselves their treatment and therapeutic path?

**Dr Plaus:** I think that misses some of the basic dynamics of what happens to those kids. They have experienced a long period of abuse and have now done considerable acting out against society, schools, parents etc. When you bring them in, in my experience, into a residential environment that is very structured and controlled, what happens is they settle down.

The majority of kids in a very structured environment, as long as it's not punitive—and that's where you have to find a balance between having a very structured treatment program and one that's sufficiently structured to the extent of being punitive, that's not therapeutic. But when you provide a safe and secure environment, the adolescents settle down and become available to treatment, become available to participate over time, and once that happens, you move them from a position of control by others, in their best interests, to control by themselves over time.

But this isn't an on or off switch, as I've said before; this takes time. We're talking about kids who have been physically or sexually abused over many years. To get them to the point of being responsible in terms of exercising autonomy over their own lives in a pro-social constructive manner takes time, several years.

**The Chair:** Dr Plaus, Ms Stamper, on behalf of this committee, I'd like to thank you for taking the time out this morning and giving us your presentation.

#### ADVOCACY CENTRE FOR THE ELDERLY

**The Chair:** I'd like to call forward our next presenters from the Advocacy Centre for the Elderly. Good morning. A reminder that you'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Ms Judith Wahl:** My name is Judith Wahl. I'm the executive director of the Advocacy Centre for the Elderly. I'm pleased to be back here again to be able to respond to the amendments that have been proposed to the four pieces of legislation.

We've not been very critical of most of it. We're actually in support of most of the amendments. I notice most of the amendments comply with the submissions we made at the earlier presentation, both our oral and written submissions. We've also been very pleased to have been included in this process since 1984 in the development of the legislation. Many of our comments we made along the way are reflected in the legislation.

1020

But I do want to make some comments about the whole system and then a few references to specific sections. Through this whole process, your committee has been receiving many different submissions and getting a great deal of criticism of all the pieces of legislation. This is very complicated legislation overall. I think ultimately



it's a system that works. I'm asking you to keep a perspective on what the system you're creating is.

Similar to my previous submissions, take note that this is a decision-making system being set up. It's a reform of mentally incompetency legislation. It's a reform of the approach that we're taking to adults and children, to people within the province of Ontario and how they make decisions. We're asking you to keep this overall philosophy in mind as you look at the details. If you forget the overall philosophy, I think the details could end up conflicting with each other.

What has been proposed in the four acts is a system for individual decision-making. The simple purpose of the legislation is to make it clear that individuals have the right to make decisions for themselves unless there's clear evidence the person is not capable. This is more than being able to express a wish or a desire. I'll come back to my comments on the use of the word "wish" in the legislation. This is the ability to make decisions or express preferences, whether verbally or in some other form.

Obviously, I'm talking about the fact that many people cannot express their preferences verbally. We have to become more sensitized to seeing that people who are not able to verbalize in fact are quite capable and can express through some other form: through expressions, touch, non-verbal means, physically.

To assist the person in expressing a preference in considering options, in making decisions, that person may need some assistance. That assistance may be information. It may be assistance in speaking out in the most appropriate and effectual manner. It may be the person giving instructions to another to have him speak for him or her. This is one of the key roles of the advocate in relation to the individual.

Another key role of the advocate and others in the Consent to Treatment Act is that of rights adviser. As rights advisers, the advocates and these other rights advisers are part of a system that ensures due process protections.

But note that the advocate is not a decision-maker. We appreciate the amendments that were made to make that clear in the Advocacy Act. The advocate is also not a rescuer. The advocate takes instructions from an individual and does not make judgements for the vulnerable person. A person, even a vulnerable person, if capable of making decisions in a particular area of his or her life, is entitled to make those decisions that others, including the advocate, would not agree with. These decisions may be made for all kinds of reasons, reasons that others think are not very good but that are important for that individual. It's part of our respecting those persons' choices.

If the person is not capable of giving instructions to an advocate, the advocate should not take action on his or her own volition, with the exception of a clear emergency. That's the balancing. That's permitting the intervention in a situation of serious danger, where there's serious danger of imminent harm. Again, we appreciate the amendments that have been made to the Advocacy Act to make that clear.

We want to emphasize that, because I know other people are making representations for a broader form of non-instructed advocacy. The advocates are not

decision-makers. If they act otherwise and attempt to be a rescuer or a decision-maker, then the advocate places himself or herself in a position of conflict, moving into a decision-making role from an advocacy, instruction-based role.

Other than in the most limited emergency situation, the advocate should not be able to act without instructions. The advocate should not be able to do non-instructed advocacy, because you have a decision-making system that you're creating with all the acts. You have provisions for substitute decision-makers. Those acts have to interact with each other. If you put too much into the advocacy basket and not connect it with the decision-making process, you're going to have acts in conflict.

The scheme already provides for a public safety net decision-maker, the office of the public guardian and trustee. I again emphasize that the Advocacy Commission should not be the public safety net decision-maker. This would be a conflict of interest, as the Advocacy Commission is established to control the advocacy services, not to be decision-makers. Those functions need to be very clearly defined: a decision-making system and an advocacy system.

We're in support of the general schemes that have been set out in all the acts. Ultimately, in our opinion, it's how these acts are going to be applied and interpreted and the resources that are allocated to make these acts work, and I can't emphasize that enough.

We're very concerned about the allocation of resources. So far, from our observations—and we of course are not privy to everything that's going on—we see a lot of resources being put into the advocacy project, which we're very supportive of, but where are the resources being placed in the rest of the system?

I'm thinking in particular of the public guardian and trustee's office. That is a very key element in the system. We have many conflicts already with the existing public trustee's office because it's not adequately supported. This system, I submit, will work to the detriment of many people unless that office as well works effectively. Some of the problems that now exist in the public trustee's office are not addressed.

Specifically, we have only a few comments on some specific sections. First of all, under the Advocacy Act, section 1, wishes and preferences: This actually applies to all the pieces of legislation. The word "wish" is used throughout the legislation: What are a person's wishes in respect to treatment or wishes in respect to decisions to be made for him?

If you look at a variety of dictionary definitions, the word "wish" is something that's unattainable. It's something you dream about, like I wish I didn't have cancer or I wish I could have chocolate cake. But a preference is something you've thought about and chosen; you've deliberated about it. I submit what we really have here in these acts is a discussion of preferences, not wishes. Preference is something deliberate.

I'm making this comment from our practice in doing advocacy for senior citizens. Many times people express to us wishes, things that they would like to have done but they don't instruct us to do. In fact, if we acted purely on



the wishes, we could be acting to the detriment of our clients. We could be doing things they really didn't want done. I think that's very important to remember. That's why I'm making the distinction between the word "wish" and the word "preference". Preference is something that's thought out. We recommend that wherever the word "wishes" appears in any of the legislation, it should be replaced by the word "preference."

We're very supportive of the sections to the Advocacy Act that make the role of the Advocacy Commission clearer. Our concern was that we were unable to really see what the system was like. I think the amendments have gone a long way to clarifying the system and resolving some of the concerns others have about how the Advocacy Commission would work.

Subsection 7(2), the authorization of non-profit agencies: We support the addition of this subsection as long as this would not exclude legal services in the term "advocacy services." In my own discussions with members of the ministry, there's some confusion about what the words "advocacy services" would mean.

I'll be quite blunt. I'm talking out of self-interest. We run our own advocacy program at this point. We have an institutional advocate. We've been doing this since 1985. We've been involved in extensive education on these acts because we've been trying to support them and encourage people to respond to your committee on it. We would like to be able to further participate, particularly in the educational processes. Of course, other social services would be in conflict with the provision of independent services. I submit that legal services are not that type.

Legal services are in fact aligned with advocacy services as contemplated in this legislation. I suggest this section be amended to include the words "or legal services" after the words "advocacy services" so you can take advantage of the systems that already exist in this province and take advantage, particularly of the legal clinics, in doing education and contributing to that process in developing the advocacy services.

We support the inclusion in the act of the specific statements that an advocate must not act in a manner inconsistent with the person's instructions or wishes, again emphasizing that we would like the word "wishes" changed to "preference."

We believe that by limiting the non-instructed advocacy to the emergency situation, it coincides with the rest of the act and makes this thing work as a system and prevents the advocate from becoming the rescuer. It has a respect for the individuals' rights to make decisions that others might not think are in their own best interests, but if they're capable of making those decisions, can so make them.

The Substitute Decisions Act: Again, we're in support of most of the amendments that have been proposed to this legislation. We particularly are pleased with the inclusion of the powers to the public guardian and trustee, which I think were an omission from the earlier draft, particularly with their powers to investigate.

Our key concern here is in terms of implementation. Will the public guardian and trustee be given the appropriate resources to plan and fulfil his responsibilities and

duties as set out in the act? Although I'm coming from the advocacy perspective, this is the office we have a great deal of contact with and our clients have contact with, and that office will continue to play a major role in the lives of people who have lost some degree of capacity. If that office isn't working efficiently and effectively, it will work to the detriment of these same people. It doesn't matter how many advocates you have in the system and how many lawyers and legal workers you have in the system, it won't work unless that office is properly supported.

1030

Will the necessary resources be made available for the education of the public and professionals working with the legislation on the details of all four pieces of legislation? I've been involved in probably over 100 presentations on these acts, many to seniors' groups and many to professionals working with seniors, and I've been appalled at the lack of information they have even on the present law, never mind the new acts. We've had repeated occurrences where the Mental Health Act is not being applied appropriately, even though it was amended many years ago. Will the resources be put in there to make sure that that public information gets out to the appropriate parties?

Lastly, with respect to this legislation, the trigger to the loss of rights of the individual to make decisions for himself or herself is primarily an assessment. The assessment process and who does the assessments must not end up being a cookie-cutter, one-plan-meets-all process. This process will be implemented by regulation. Appropriate resources must be allocated to the development of the assessment process and the selection and training of assessors. The assessors are not menial workers; they're key players in whether these people's rights are respected or not.

Under the Consent to Treatment Act, section 1, rights advisers, we support the inclusion of persons other than the advocates authorized by the Advocacy Act to be rights advisers for the purposes of this act. However, it must be made clear that these additional rights advisers cannot be persons who are delivering the health and social services to the persons or associated with the health care practitioners who are determining whether this person is capable of giving consent to treatment. The rights advisers must have the same independence, be the same step removed from the health care practitioner, in order to really give that person who's allegedly incapable the due process rights that you're trying to put into the legislation. It is recommended that this section be amended to make this clear.

We also support the changes to the requirements for the advocate visit in other places. This is a practical solution in balancing to this problem. Some concern has been expressed, particularly by seniors on our board, about the ability for family members to consent to treatment. We're not making recommendations for changes to this section, but we're flagging it for you because we're very concerned, based on our experience of the warring relatives, such as the daughter from California who comes in and starts making treatment decisions for a parent who is not capable of making decisions and then it turns out that the person has had no contact with the older adult for many years. We understand the practical reasons for making this



recommendation, but our concern is that it be carefully watched because this may be a section that requires amendment in the future if abuses do occur.

Development of the four pieces of legislation is only the first step in the reform of this whole system. We must all continue to be vigilant and to scrutinize how legislation is implemented and interpreted, as the protection of all of our rights depends on it.

**The Chair:** Thank you very much. Questions and comments?

**Mrs Sullivan:** I have two questions relating to your comments with respect to Bill 109. The first relates to your advice that rights advisers cannot be persons delivering services such as health and social services to the individual or persons employed or associated with the health practitioner who is making the allegations that the person is incapable of decision-making. It's my impression that the intention of the government is, because of amendments that have been made to the bill, to place the burden of employing rights advisers on the institutions that are covered in the act, whether they are hospitals, nursing homes and so on. Your view is that a rights adviser should not be associated with the delivery of treatment or health care services. Is it your view also that the rights adviser could not be the health practitioner himself or herself?

**Ms Wahl:** I believe that is true. It has to be somebody outside. The health practitioner has a certain role to play already. They are required to tell the person that he or she is entitled to receive rights advice. If they're also the rights adviser, they're in a position of conflict. You're asking them to do two jobs. It's the same thing with the person who is employed by the institution.

In effect, I could see a system in which you have rights advisers at a hospital, for example, but that rights adviser is not accountable to the chief executive officer. He is in some way accountable back to the advocacy system. Maybe they're funded through the health system, from the hospital system, but whether they're employed or not doesn't depend on the hospital staff, because otherwise you're going to get a situation where you're not really giving the appearance of justice. You have to give the person due process. If you're not giving them independent advice, where's your due process here?

**Mr Jim Wilson (Simcoe West):** Thank you very much for your presentation. What is your—to use your word—preference in terms of implementation of this legislation? I'm thinking in particular of the development of the regulations. Should we, for example, be legislating at this time a process by which we can ensure that the public is fully involved in the development of subsequent regulations to this legislation?

**Ms Wahl:** That's a hard question for me to answer, quite frankly, because I don't know enough about the processes of governments and how the regulations come into being and how the public is consulted or has it been consulted in the past.

Obviously there are key regulations to these acts. The example we're giving is about the assessment. I would think the public does have a contribution to make.

At the same time, I don't want to hold up the process of this legislation. Personally, I've been involved in this since 1984. I'm very anxious for many of my own clients that these schemes come into place at some date in the immediate future, not five years from now.

**Mr Jim Wilson:** But does it concern you that we, as elected representatives, are being asked to pass legislation that really doesn't contain a clear definition of what an assessor is or what the competency of an assessor would be or the rules and regulations defining assessment? I'm not even really sure what an advocate is any more, because every group comes with a different vision of what an advocate is and who these people will be and the rules and responsibilities governing the commission.

**Ms Wahl:** I'm not concerned enough to say, "Stop the legislation," not by any means. This is too important. There are too many parts to this legislation that are too important. I think the public and the opposition and the government have to watch very carefully the regulations that do come into play. They have to be consistent with the intent of this legislation.

**Mr Jim Wilson:** I mention it because, being realistic, we're not going to stop the legislation, nor have any of the parties suggested that it be stopped in whole. I think, though, it's useful to hear your comments, because now we have the opportunity to perhaps put a process in place where people will have greater input into the regulations and some assurance, because you know how regulations are done. They're published in the Gazette after the bureaucrats cook them up and they go through cabinet, and very, very often they're in place, the professionals have to deal with them, and the public is really caught off guard.

**Ms Wahl:** I really can't provide any more comment.

**Ms Jenny Carter (Peterborough):** Thank you for a well-thought-out presentation. You show that you do understand what we're trying to do with these acts.

There's one point you raised that I'd like to hear further from you about, and that is the way in which the different acts mesh together. You obviously see the advocate as doing everything possible to communicate with a vulnerable person, even if it's somebody who is non-verbal or who may be quite severely handicapped as far as expressing their preferences goes.

Do you see any conflict between advocacy and the guardianship provisions of Bill 108? Do you feel that a person might be given a guardian who, if given the support of an advocate and maybe other people around him, would be able to make his own preferences known and function without a guardian?

1040

**Ms Wahl:** I see these acts working together as a kit. That's why I keep emphasizing that you have to look at the overall scheme, because I don't see a conflict between the advocates and the guardians from my vision of this legislation. You shouldn't have a guardian if you're capable enough of functioning with assistance.

I'll give you examples from some of my own clientele. I've had clients who have been aphasic, with tremendous difficulty in communication, but they are not incapable;



they don't need a guardian. They can give me instructions as their advocate. It's looking at that individual situation. So you have advocacy for the individual right up to the point that they are not capable; then you have a guardian, but the guardian can work with the advocate to assist that person. We sometimes, on a rare occasion, assist family members advocating on behalf of older adults who are now incapable of giving us instructions. So it has to work as an integral system.

**Ms Carter:** And you feel we've got that sufficiently defined?

**Ms Wahl:** I think the acts define it. Again, it's going to be how it is implemented.

**The Chair:** Ms Wahl, on behalf of this committee, I'd like to thank you for taking the time out this morning and giving us your presentation.

THE COLLEGE OF PHYSICIANS  
AND SURGEONS OF ONTARIO

**The Chair:** I'd like to call forward out next presenters, from the College of Physicians and Surgeons of Ontario. Good morning. Just a reminder that you'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourselves for the record and then proceed.

**Dr Rachel Edney:** Mr Chairman and committee members, thank you for the opportunity to participate in another round of public hearings on consent and advocacy. I am Dr Rachel Edney, president of the college council. With me are Dr George Morrison, past president; Mr Bala Nambiar, senior public member of council; and Dr Michael Dixon, the registrar of the college.

As you will recall, we came before you in February to warn you that the original bills would seriously jeopardize a patient's right to receive appropriate and timely treatment and that the consent act couldn't be effectively implemented unless it was workable and understandable for patients, families and practitioners.

In its amendments to those bills, the government has made significant efforts to try to resolve the problems while protecting the patient's right to consent and the interests of vulnerable persons. We believe these are fundamental principles and we believe legislation is required to protect them, but the consent and advocacy acts are still not ready to enter the real world of Ontario's front-line health care system. I hope that we can assist by providing further suggestions.

In February, I used examples from daily practice to illustrate our points. This legislation remains so complex that I believe it is the best way to discuss it again.

A divorced father brings his 14-year-old daughter into my office. The mother normally has custody, but the girl is visiting the father for several days while the mother returns from an extended trip. The teen is suffering from diarrhoea and has not been able to keep much food or liquids down. The condition has lasted for two days and doesn't seem to be ending.

I examine her to determine what the problem is. I find she's dehydrated and has some abdominal pain. She appears to have gastroenteritis, or stomach flu. The young woman is certainly feeling ill, but you could conclude on "reasonable grounds" that she is not experiencing "severe suffering" or at risk of "serious bodily harm." Nevertheless, she does require an intravenous solution to restore her body's fluids, and I'd like to conduct further tests to rule out more serious causes of abdominal pain.

I am uncertain but suspect that her condition could be indicative of a beginning appendicitis or could even be an ectopic pregnancy. To determine this, I would order blood tests, X-rays and perhaps a laparoscopy, which is an invasive procedure where I would insert an instrument into her abdomen to visually observe the situation. I suggest she be admitted to hospital overnight.

The 14-year-old is irritable and sulky; she just wants to go home. She and her father are not getting along, and she objects strongly to my suggestions. At the moment her condition is not life-threatening but, depending on the diagnosis, it has the potential of quickly becoming a serious condition without active medical treatment.

At this point there are several possible outcomes. I accept the teenager's decision to refuse over her father's objections and she goes home. In the middle of the night she awakes with acute abdominal pain and almost dies before she gets back to hospital for emergency surgery for an ectopic pregnancy.

Or, according to Bill 109, section 10, I conclude that the teenager, because of her emotional state, is "incapable with respect to a treatment." The act is unclear as to whether or not my office will be a prescribed facility, or whether the treatment I am proposing is "a controlled act...other than a prescribed controlled act."

However, according to the bill, I advise her of my finding, give her a written notice and notify a rights adviser. The act is unclear as to who that rights adviser will be.

The teenager refuses to meet with the rights adviser, who informs me of this fact. I turn to the father who, although he does not have permanent custody of the child, is present and prepared to give consent under section 16. I accept his consent and admit the young girl to hospital where we begin intravenous fluids. Tests reveal she has simple stomach flu and she recovers quickly.

Or, finally, the teenager meets with the rights adviser. She just wants to go home, so she says she'll appeal my decision to the board. I must now ensure that she receives no treatment until either seven days have elapsed or the board has made a decision and the appeal period has elapsed. You could conclude on reasonable grounds that a case of stomach flu will be better within that time period, or you could conclude that a suspected ectopic pregnancy is a potential emergency which would, of course, allow me to treat.

However, the father is angry and takes the girl to the emergency ward where he finally convinces her to agree to the hospital doctor's proposed treatment. The tests indicate an ectopic pregnancy and she receives appropriate care.

These scenarios illustrate several points which Dr Morrison will outline.



**Dr George Morrison:** There has been much debate over where the government should set the age of presumed capacity at 12 or 16. If it is set at 16, as in the original Bill 109, it could prevent many young teens from consulting practitioners about birth control or sexually transmitted diseases.

If it is set at 12, as in the amended bill, you have situations where immature teenagers can make decisions that are clearly not in their best interests because of temporary emotional upset.

The parliamentary assistant, Mr Wessinger, was recently quoted in the media expressing frustration over this issue and we have sympathy for that. But the dilemma will always exist, no matter where you set the age.

The solution is to try to create the same kind of flexibility as provided by the common law where a young person between the ages of 12 and 18 makes a significant health care decision that is clearly not in his or her best interests.

As Bill 109 currently reads, the entire rights adviser-review board process must come into play in these cases when the practitioner concludes the person is incapable with respect to a treatment, thus inserting itself between the child and the parent or legal guardian in all instances of dispute. This will not work in the best interests of patients and their families.

Our recommendations therefore are that the government can substantially reduce the extent of this problem by ensuring that offices, clinics and acute care hospitals should not be a prescribed health facility.

The government has also introduced the concept of a "controlled act...other than a prescribed controlled act" as one way to try to minimize the original bill's logistical quagmire and focus its requirements on significant treatment decisions. This may also help solve the age difficulty, but the government will need to clarify how it intends to draft the appropriate regulations.

Third, we recommend that section 10 of Bill 109 be amended so that common-law principles are followed for persons between the ages of 12 and 18. In these circumstances, the health practitioner may notify the rights adviser if clauses 10(4)(a) and (b) apply, or accept the decision of the parent or guardian.

1050

This example also focuses on the frequently imprecise nature of an emergency. In the original Bill 109, the emergency provisions were so restrictive as to jeopardize a patient's right to appropriate and timely care. In today's example and in the scenario we used during the first hearings, we described situations that are common occurrences, where there are few solid facts and frequently no hard and fast rules. In such cases, it is the practitioner's judgement, his or her training and experience, that must guide proposed treatment decisions.

The amendments to Bill 109 have solved much of the original difficulty. A practitioner can conduct an examination without consent if it is reasonably necessary to determine if a potential emergency exists. But in our two scenarios, the definition of what constitutes an examination is very important. For the young teenager, a laparoscopy

might be necessary to diagnose her condition. In our February example, I would have to do a lumbar puncture, an invasive procedure that could be considered to put the patient at some risk, but necessary to determine if she had meningitis.

In either circumstance, the existence of an emergency could not be determined reliably without diagnostic procedures that might not normally be considered part of a routine examination. The act should ensure that health practitioners can conduct an examination to the extent necessary to determine if an emergency exists.

Our recommendations are, therefore, that subsection 1(1) of Bill 109 be amended by striking the paragraph referring to treatment and substituting the following:

"'Treatment' means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a diagnostic evaluation or a course of treatment;

"'Diagnostic evaluation' includes the performance of such examinations or investigations as may be reasonably necessary in order to determine whether the circumstances set out in clause 22(1)(b) exist or to form the opinion set out in clause 22(2)(b) of the act."

Our two examples highlight another point, the issue of liability. Section 24 of Bill 109 states that a practitioner is not liable under this legislation if he or she acts on reasonable grounds.

In our first example, insisting the young teen be hospitalized may be reasonable if she has an ectopic pregnancy but not if she simply has stomach flu. Deciding on appropriate treatment is an exercise in professional judgement, often in the absence of solid facts. Different patients have different needs under different circumstances.

The consent bill recognizes the need for professional judgement. It asks a health care practitioner to judge whether patients are at risk of serious bodily harm, whether they are experiencing severe suffering and whether an emergency exists now or will exist 10 hours from now.

At the same time, the government is asking practitioners to observe legislation that, despite many amendments, is still exceedingly complex and technical. What is the goal here? Does the government want practitioners to act in the best interests of their patients or to act according to the letter of the law regardless?

Last year before this committee, the Minister of Health expressed concern about creating a situation where practitioners felt it necessary to observe the technical requirements of the bill rather than using common sense; we share that concern. But by setting up a bureaucratic legal standard of reasonable grounds in all circumstances, the government will encourage health care workers to observe technical compliance above all else.

If the government wishes to ensure that the interests of vulnerable or incapable people come first and do not get lost in bureaucratic interpretations of the act, then it should allow health care practitioners, whether nurses, midwives or doctors, to act in accordance with the judgement they are trained to deliver; in other words, in good faith.



The government would appear to believe that vulnerable people in need of advocacy services are best served by this approach. In section 9 of Bill 74, advocates are allowed to exercise their trained judgement in good faith. We believe all patients deserve this protection.

We see another problem in section 9. We are concerned that the government proposes to weaken its protection for vulnerable people by protecting advocates from any liability for "alleged neglect or default." If the act's requirements for qualifications and standards for advocates are to be taken seriously, and if the proposed complaint process is to have credibility, we question the need for this phrase in that bill.

Our recommendations therefore are:

Subsections 24(1) and 24(2) of Bill 109 should be amended so that practitioners may act on an apparently valid consent or refusal "that a health practitioner believes on reasonable grounds and in good faith to be sufficient for the purposes of this act."

Subsection 24(3) of Bill 109 should be amended to read, "A health practitioner who administers treatment to a person in good faith and in accordance with section 22 or 23.1 or who refrains from doing so in good faith and in accordance with section 23 is not liable for administering the treatment without consent or for failure to administer the treatment, as the case may be."

Mr Nambiar will make our final points.

**Mr Bala Nambiar:** Advocates will frequently work in the health care system, so great care must be taken to balance their access to information with the public's right to privacy and the government's goal of promoting quality assurance. We do not believe that sections 24 and 25 of Bill 74 achieve this. Both sections could be used to gain access to many kinds of confidential records, in some cases without the consent of the person to whom the records relate.

For regulatory colleges, that could include complaint files. For many patients the confidentiality of their complaint is very important. In hospitals advocates could see records related to quality assurance activities. Access to these files could discourage the thorough and honest peer scrutiny so critical to quality management. Both groups of files are currently subject to specific privacy rules. The government is considering steps to tighten them even further under the Public Hospitals Act and proposed confidentiality legislation.

We are particularly concerned about protecting the confidentiality of complaint files. For example, section 25 lets advocates review records relating to an individual without that person's consent if the Advocacy Commission believes that systemic policies detrimental to vulnerable persons existed in a facility or program prescribed by regulations under the act. There is no provision for a facility or organization to challenge or appeal a decision by the commission or an advocate to access such records.

What does Bill 74 mean to a woman trying to put together the emotional strength to make a complaint of sexual abuse against a doctor? It means that a patient representative at the college to whom she provides private information must warn her that the college cannot guarantee her confidentiality.

Should self-regulating bodies be captured by this provision, it will create a serious barrier to patients coming forward with complaints about health professionals. It is difficult enough to encourage women who have been sexually abused by doctors to come forward. It will be almost impossible to convince them to do so if we cannot promise that their files will remain confidential.

We therefore recommend that clauses 34(1)(c) and 25(1)(c) allow access to records in the custody or control of "a person who operates a program prescribed by the regulations made under this act." Regulatory colleges should not be prescribed in these regulations. Bill 74 should prohibit access for the purposes of advocacy to records in hospitals and facilities pertaining to quality assurance activities.

#### 1100

We further recommend that Bill 74 ensure that access to patient files for the purposes of individual or systemic advocacy can only be obtained with the consent of the person to whom the file pertains or the consent of his substitute decision-maker; provides for written notice to organizations identifying the specific records to be accessed; and creates a mechanism for facilities or organizations to appeal a decision by the Advocacy Commission regarding access to records.

Finally, we would like to express our continuing concerns over the complexity and implementation of these acts.

Despite the government's efforts, Bill 109 remains a very complicated piece of legislation. How will it protect the patient's rights if consumers, families and practitioners are left scratching their heads as to what its meaning is?

For example, the bill states that "If, in a place other than a psychiatric facility or prescribed health facility, a health practitioner finds that a person who is 12 years of age or more is incapable with respect to a treatment that is a controlled act within the meaning of...the Regulated Health Professions Act, 1991, other than a prescribed controlled act, the health practitioner shall ensure that the person is given a written notice (which may be in the prescribed form) indicating that the person is entitled to request a meeting with a rights adviser and is entitled to make an application to the board under section 26."

Could someone please explain what this will mean to a doctor in a community clinic?

Or what about this one, where substitute consent can be given "if the person who is present is a person described in paragraph 5, 6, 7 or 8 of subsection (1), he or she has reason to believe that a person described in an earlier paragraph of subsection (1), other than paragraph 1, 2 or 3, is available and would want to make the decision to give or refuse consent" etc.

With all due respect, I wonder if anyone can sort through that one without the legislation itself sitting handily at the patient's bedside.

Both patients and practitioners are going to have great difficulty understanding what their rights and obligations may be in certain circumstances.

As the regulatory body for the medical profession, we have serious concerns about being able to provide simple, clear policy guidance to members of the profession who



want to know what they can do and under what circumstances.

For example, section 10 contains an array of different notification requirements depending on where a treatment is to occur, whether it is a controlled act, an emergency or the patient objects.

In section 13, patients will need to clearly understand how to make their wishes and preferences known and under what circumstances. They will have to understand that a casual statement to a potential substitute decision-maker today could be regarded by that person as an expressed wish tomorrow under entirely different circumstances.

Thousands of individuals, health care workers and institutions will be affected the day this bill becomes law. To ensure that it is applied consistently and not unintentionally circumvented because people can't understand it, a major public and professional education campaign will be needed before implementation. Without this, the act will not meet its objectives.

While each professional organization and regulatory college must play its part, this has to be a government-led initiative which takes the time to reach out to all health care workers as well as the public.

We therefore recommend that:

The Ministry of Health should put together a working group of health care professionals and providers, patient representatives and ministry officials to develop comprehensive and uniform policy guidelines for the public and practitioners before the act is proclaimed. These guidelines should be issued by the government as interpretative notices; and

The government should establish a consultation process regarding the regulations under Bills 74, 108 and 109 so that potential problems can be identified before the acts are proclaimed. The process should be similar to the consultation process for regulations under the Regulated Health Professions Act.

That concludes our presentation. We look forward to your questions.

**Mrs Sullivan:** We appreciate this brief. I think you have provided a lot of very useful guidance to the committee in terms of recommendations with respect to liability, treatment, diagnostic evaluation and access to records. Certainly the request you make with respect to the implementation of these bills and consultation on the regulations is one I hope the government will take seriously.

I wanted to pursue with you the points you made with respect to section 10 of the bill which does two or three things, one of them defining the responsibilities of a doctor or other health care practitioner differently, depending on the different location of the diagnosis or treatment recommendation, and being very vague in terms of what would be a prescribed act or a prescribed controlled act under the regulations and what wouldn't be.

Second, as I read this, it would mean that a pelvic examination, by example, in a physician's office perhaps, would be treated differently and the obligations on the physician would be very different than if that pelvic examination were to be conducted in a hospital, assuming that a hospital is a prescribed health facility, which we

don't know. I suspect that, of your recommendations, that's one that won't wash with the government.

Can you speak to that issue? I think it's highly problematic for physicians and certainly for patients.

**Dr Edney:** That is a real problem, just the understanding of it. I think that is the major problem, that the physician, particularly as you may have the same physician working in those two facilities, has to try and understand and remember what he or she has to do in the office as opposed to what he or she has to do in the hospital.

I think we're creating immense confusion, and with the public as well. They will have great difficulty in knowing why it is that I can do something in my office, or can't do something if they ask me not to, and the same thing doesn't apply in the hospital. I think the understanding of this for the physician is going to be extremely difficult.

**Mrs Sullivan:** Is there any other area of medical law, or areas where the college has jurisdiction, where you would see requirements placed on a physician that depend on the location and not on the treatment?

**Dr Edney:** Maybe Dr Dixon can answer that.

**Dr Michael Dixon:** With the exception of the Mental Health Act and the Mental Hospitals Act, no; specifically to answer your question, no, with that exclusion.

**Mr Jim Wilson:** I want to thank the college this morning for once again appearing before the committee and presenting us with an excellent brief and with a scenario that is quite disturbing and which you used to raise a number of concerns.

I want to say from the outset two things. One is that in my party, on the basis of the second round of these hearings, we are certainly taking a very serious look at the age issue with respect to capacity.

Second, I think we continue to be disturbed that this legislation in our view appears to be anti-professional. It appears to continue to reflect a philosophy that somehow professionals have been generally incompetent in dealing with their patients and that there's been a lack of fairness out there—as the Premier likes to use the word constantly in other contexts—and that the power relationships between patients and doctors have been skewed in favour of doctors. It really raises a lot of concerns that in some ways are philosophical but in other ways, none the less, are very, very disturbing.

I want to ask you, as this is the second round and there have been 199 amendments introduced, whether your comfort level is higher now with respect to the amendments that have been introduced?

**Dr Edney:** Yes, it undoubtedly is. We have been very pleased that we were listened to and that many amendments were introduced. I think we still do share some of your concerns that this does sometimes appear to be an act that is anti-professional, not just anti-physician but anti-nurse and many other professions.

We undoubtedly agree there are situations in which something similar to this act is needed, but that perhaps this is going to cause so much confusion when in fact there are far fewer situations in which it's really needed.



To answer your question, yes, we are more comfortable but we do share some of your concerns.

**Mr Jim Wilson:** I am sincerely pleased to hear that, because the legislation will go through in some form. I think that's inevitable because of the government's majority in this parliamentary democracy. None the less, I note in a press release, which you're putting out accompanying your presentation today, that you really would like to see, as I read here, a real consultation process with respect to the regulations. Do you want to expand on that concern?

1110

**Dr Morrison:** Even the introduction of the health professions legislation with its regulations has involved consultation with the people affected, all of the various colleges. There certainly is some consultation that goes on, but we see a need for even more of that. We see the need to have an expansive education program introduced and a game plan established that's already in place from the time that this legislation is ready to go, even to the extent of having some kind of interpretation bulletins that will make it clear to the practitioners of all specialties how they are to behave in given situations.

**Mr Owens:** Dr Morrison, I think you hit the nail on the head when you used the phrase "common sense." It's unfortunate that we as legislators cannot legislate common sense. In terms of your view of dropping the age of consent from 16 to 12, I think what you're going to find in terms of common sense, as well as what I'm sure we're going to demonstrate in terms of common law, is that the ability to understand and appreciate the consequences of the refusal or the acquiescence to a treatment is probably more important than the person's age.

I wasn't here during the February hearings when you presented the case of the person with suspected meningitis, but I guess my question is, how would you draw spinal fluid from a non-compliant patient? What has the profession done up to now in terms of dealing with individuals, whether they're 12, 16 or 47, in the light that not all patients are compliant when they're presented either in emergency or in your office?

**Dr Morrison:** In meningitis, a lumbar puncture done in an infant, which is perhaps the most common one in the younger age group, is done by bundling them. They clearly are under 12 and it does not apply to them but to the individual who is resisting. There is a degree of resistance where one can mollify the patient sufficiently to achieve the positioning and then do the procedure without getting into trouble. Our major concern is that you wouldn't be able to even propose doing this to them until they had given a consent. We think you should put into the law the principle of common law that says that between 12 and 18 we can apply or accept the decision of the parent or guardian in that situation.

**Mr Owens:** Would there be other pieces of legislation that perhaps would kick in in terms of a contagious disease like meningitis that has the potential to spread, whether it's the Health Protection and Promotion Act or other such pieces of legislation? In terms of the example of gastroenteritis, not being a medically trained person, it's my understanding that

gastro has the potential to be quite serious and can potentiate an emergency. Can you not use the proposed language to treat, or even common sense again, if you have a suspicion that it's an ectopic pregnancy?

**Dr Morrison:** I'm going to ask the registrar to answer that question in relation to the other legislation because I'm not positive about the answer to that.

**Dr Dixon:** I don't think that's relevant, with respect. But I think the issue of the assessment of an emergency depends on the standard you put of whether it's a good-faith assessment or whether it's reasonable grounds. You're not really making clear what the onus on the practitioner is.

**Mr Owens:** You would like to see a clarity in terms of the onus.

**Dr Dixon:** Also, the practitioner must have the ability to make the assessment prior to making the conclusion as to whether it's an emergency or not.

**The Chair:** Dr Edney, Dr Morrison, Mr Nambiar, Dr Dixon, on behalf of this committee, I'd like to thank you for taking the time out of your busy schedules and coming and giving us your presentation this morning.

#### ONTARIO HOSPITAL ASSOCIATION

**The Chair:** I'd like to call forward our next presenters, from the Ontario Hospital Association. Good morning. Just a reminder that you'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Dr Brian McFarlane:** My name is Brian McFarlane. I'm the CEO of the Toronto Doctors Hospital, and I'm addressing the committee today in my role as chairman-elect of the Ontario Hospital Association. With me is Carolyn Shushelski. She is the senior legal counsel for the OHA.

Thank you for the opportunity to speak to the committee about Bills 74, 108 and 109 and the government's proposed amendments to these bills. The OHA would like to acknowledge the considerable efforts by the government and the committee which resulted in the introduction of the package of some 200 amendments to meet concerns raised by our association and others earlier in this process. While many of these concerns have been addressed, certain substantive issues remain outstanding and must be addressed. We will address some of these issues in our discussion today, but we would urge you to read our submission, which outlines our concerns in detail.

OHA's submission to this committee in February stressed that the bills were unworkable, they imposed an unnecessary bureaucratic barrier between patients and the delivery of care and would increase hospital operating costs at a time when the health care system is experiencing severe financial constraints. We are not here today to go over that ground yet again. However, we hope you will keep these concerns in mind to the extent that they have not yet been addressed.



First, on implementation: Once the legislation has been finalized, it must not be viewed as the journey's end; it should be regarded as the foundation from which the plan for implementation must be launched. Potentially, the greatest benefit from this legislation can be realized with the greatest number of persons only when the public and health practitioners are aware of and appreciate the potential impact that this legislation can have on them.

We believe it is essential that the government ensure that adequate provision is made for the implementation of the legislation. Specifically, this will include the education of the public about the intent and potential impact of the legislation, the education of health practitioners as to their obligations under the legislation and the consultation and participation by OHA and other interested groups in the development of regulations to be made under this legislation.

Let me first deal with the issue of education. To achieve these goals the government should ensure that an educational program is implemented on two fronts, namely the education of the public and the education of health practitioners as to their obligations. We recommend that the government ensure that the education programs for the public and health practitioners be provided prior to the implementation of the legislation.

The implementation period must be adequate to ensure that the following areas of concern are addressed in the educational programs before the legislation is actually proclaimed in force: a public education program that is intended to make individuals aware of the intent and potential impact of the legislation on them as individuals and also as family members who will have obligations under the legislation, an education program for health practitioners that is intended to make them aware of the intent of and their obligations under the legislation, and a public education program that makes individuals aware of how they can take advantage of the legislation to plan for their future health care or property management should they become incapable.

1120

Second, review after implementation: Upon implementation it may be that certain aspects of the legislation are problematic from a practical standpoint. Provisions should be made now to review the legislation after it has been in effect for a reasonable period of time. Following this review, the legislation could be revised if necessary.

Third, development of regulations: Many of the proposed amendments have incorporated provisions that will be prescribed by regulation. We acknowledge that such provisions may permit flexibility in the actual implementation of the legislation. Nevertheless it is difficult to provide meaningful comment on these provisions because we do not know what the provisions in the regulations will require. The regulations will be an important and integral part of the legislation. We strongly urge that the OHA and other interested groups be given an opportunity to participate and comment on the proposed regulations.

Bill 109 is proposed to be amended by substituting the term "rights adviser" for persons who were previously designated as "advocates." We support this amendment. The role, training, accountability, remuneration and availability

of rights advisers must be clearly defined under Bill 109. In fact, we believe the administration and jurisdiction of rights advisers should be under the Minister of Health and the Consent to Treatment Act.

Rights advisers should provide rights advice and facilitate appeals to the Consent and Capacity Review Board. They should not overreach that mandate to become involved in systemic or case advocacy. Furthermore, rights advisers should be available 24 hours a day, seven days a week, to provide rights advice to individuals deemed incapable to consent to treatment.

The definition of "treatment" in Bill 109 has been amended to state that it does not include "a prescribed thing" which will be designated at a later date. We support amendments that will permit a greater degree of flexibility and allow for appropriate treatment to be rendered properly. However, we do not know what these regulations are to be. Thus we cannot provide meaningful comment on this proposal. We request that OHA be consulted on the development of regulations that prescribe these things under this provision.

The provision of emergency treatment is a key function of many hospitals. In our opinion the emergency provisions in subsection 22(1) should not be limited to only subsections 10(11) and (12), which deal with board applications, hearings and appeals. Rather, the emergency provisions should apply to all of section 10.

New subsection 22(3.1) introduces the word "examination" into the bill. We support this amendment. We would make a further recommendation: The definition should state that a health practitioner may perform those examinations and assessments that are necessary to make a diagnosis and/or determine whether the patient is experiencing severe suffering or is at risk of suffering serious bodily harm.

The complexity of legislation is exacerbated by the fact that the proposed amendments to section 10 of Bill 109 introduce one set of rules to be followed by health practitioners who work in a psychiatric facility or a prescribed health facility and another set of rules for those who work in other settings. We believe that a single set of rules would facilitate consistency and promote compliance. It is not clear at this time whether a public hospital will be included by regulation as a "prescribed health facility" under section 10. We believe hospitals should not be prescribed health facilities for the purpose of section 10.

Furthermore, we suggest that the finding of capacity should relate more to the kind of treatment being proposed rather than the place where the treatment is being administered. We continue to have serious concerns with respect to patients whose conditions do not fall into the emergency category. The requirements of section 10 can delay treatment where it is not emergency treatment. Persons found to be incapable of consenting to treatment may suffer from pain which is not severe in nature or may be at risk of bodily injury that is not of a serious nature. The pain cannot be alleviated or the injury treated because it does not meet the definition of emergency treatment. These persons will fall into a wide grey area and be subject to the procedural delays to treatment imposed by section 10.



Consider the case of a senior suffering from a disorder who has injured her wrist in a fall. Although her injury would not be considered an emergency, she's still in need of treatment. An attending physician must comply with section 10 of Bill 109. This could easily include notice, rights advice, board applications, hearings and appeals. The time it takes to comply with all of these steps could be days, if not weeks or perhaps longer. In the meantime the patient needs her wrist fixed.

The legislation must be amended to reflect the reality of the hospital setting. Patients arrive and they need to be treated. Even if an advocate is available within a reasonable time frame, if the patient chooses to have a board hearing the treatment must be delayed until all of the procedural elements of section 10 are satisfied. This will take days or perhaps weeks. What is to be done with the patient and his or her pain or injury? Appeals to the court from a decision of the board would take months.

Bill 74: We continue to have concerns about the extraordinary range of powers given to the advocates under Bill 74. Sections 24 and 25 of Bill 74 deal with access to records by advocates and the Advocacy Commission. These provisions give sweeping powers to advocates and the commission, but few safeguards exist in the legislation.

For example, patients can be deemed vulnerable but it is not clear who has the authority to deem them so. In the case of section 24 it appears that advocates make this determination. In the case of section 25 it is not clear whether the commission has this authority. By virtue of the definition of a vulnerable person, practically anyone could be deemed vulnerable. Once this designation is made, then certain rights by advocates and the Advocacy Commission are triggered pertaining to access to records.

Also related to the issue of access to records is the designation that someone is incapable to consent to the release of records. It appears that advocates can determine that someone is incapable to consent to release of records, but there is no requirement for that person to be advised of this or to challenge this finding. The commission has wide powers of access to vulnerable persons' records and indeed to any records in a facility. Again, there is no requirement to notify the person that his or her records are being accessed or to give the opportunity to refuse the access.

We recommend that safeguards be legislated to include such things as an assessment by a person who is trained and qualified to make determinations of incapacity, notice in writing of a finding of incapacity and a right to appeal this decision. Where a person is deemed vulnerable, he or she should be so advised. Where a person's records are to be accessed, he or she should be advised and have the opportunity to refuse the access.

The bill should also include procedural steps such as written notice to the facility or organization identifying the specific records to be accessed. The facility should be empowered to refuse to disclose certain records where the information is sensitive due to the fact that it relates to medical audit, quality assurance or risk management. The facility must be allowed to challenge this information access.

The bill contains provisions which attempt to clarify which legislation prevails. There's still some confusion

since other legislation contains similar provisions. This needs to be clarified.

1130

A facility or organization should have the right to challenge a decision of the commission that a policy or practice of the facility is detrimental to vulnerable persons. First of all, the facility should be given written notice of the decision. Second, there should be a right of appeal up to the courts. Third, the facility should be allowed to refuse to disclose information related to other persons, peer review or medical audit information or other sensitive information.

We believe that the powers of entry given to advocates under Bill 74 are excessive and unjustified. Dispensing with warrants, and the necessity of showing a compelling reason for needing one, imperils everyone's right to privacy. An advocate could, under the bill, walk into a hospital treatment room or an intensive care unit. This is inappropriate and an extreme invasion of privacy.

We recommend that provisions similar to those for controlled access residences be put into place for facilities. This would mean that advocates could only enter common areas of the premises.

We have concerns with the composition of the Advocacy Commission. For an effective commission, the membership should be broader and include families, consumers, health care and social service professionals and providers. The bill should guarantee that these persons are included as members of the Advocacy Commission.

The legislation should include a mechanism whereby individuals who have a complaint about the decision or actions of an advocate or the Advocacy Commission may appeal for the review of those decisions.

The amendments to Bill 74 require the minister to establish an advisory committee. However, the committee is given no particular mandate. This should be formalized in the bill. Further, we believe that the committee should be required to submit an annual report to the minister and it should be tabled in the Legislature by the minister.

Bill 108: As you know, hospitals operate seven days a week, 24 hours a day. Under Bill 108, the public guardian and trustee is to establish and maintain a register of guardians of property, guardians of the person and attorneys under powers of attorney for personal care. The legislation must clarify that this register is to be available on a 24-hour basis.

We have concerns with the provision in the bill that permits more than one person to have powers of attorney for an individual's personal care. What happens in the event of a dispute? What happens if one or more attorneys are not available to make a decision? These matters should be addressed in Bill 108.

In conclusion, we believe these bills will have a significant impact on the provision of health care in this province. We appreciate the well-meaning intent of the legislation. However, in our view the legislation as proposed continues to impose obstacles to prevent health practitioners from providing proper treatment promptly in certain circumstances, and this must be rectified.

We need to develop legislation that ensures that our health care facilities are places where care and treatment of



patients is the primary concern. We believe that the ultimate goal of all interested parties is to create legislation that will be workable, safe and ultimately improve the quality of life for all persons who will be affected by this legislation.

We hope our comments will be useful in achieving this mutual goal, and we thank you for the opportunity to make this presentation. We would be pleased to answer questions you may have.

**The Vice-Chair (Mr Mark Morrow):** Thank you very much. Any comments or questions?

**Mrs Sullivan:** We appreciate this brief. It's been very thorough in the analysis. We also appreciate the recommendations you've made in some detail with respect to additional amendments that would make the bills more useful.

I wanted to concentrate in questions on the remarks that you've put forward with respect to section 10. Your recommendation, which is comparable to that of the College of Physicians and Surgeons, that hospitals not be described as prescribed health facilities. My view is that the government has in fact made the amendments to section 10, including changing the advocate to the rights adviser, and will be, through regulation, in fact presenting a greater burden to the hospitals.

You've already noted that rights advisers would have to be on call 24 hours a day, year-round. In hospitals of size, clearly there'd have to be more than one available. My view is that the Ministry of Health's other shoe is going to be to say to hospitals that hospitals will have to pay for those rights advisers, employ them and provide facilities for them in the institutions. Your recommendation that public hospitals not be prescribed health facilities is one that the minister will not look favourably on. I wonder what your response to that scenario would be.

**Dr McFarlane:** The question of hospitals having to staff for this would be a significant impact on hospital operating budgets. As many of you are aware, there are significant operating cost constraints in hospitals today, and we need to lessen that burden rather than add to it.

**Mrs Sullivan:** I think that's what the intention of the ministry is. I'm certainly aware, with a 1% change this year with bed closings around the province and some areas of the province now being underserved, that the implications would be quite extraordinary for hospitals. The difficulty, as well, for health practitioners who are working either in a hospital setting—presuming that a hospital is a prescribed health facility—or in another office or in a community base or on an outpatient basis is it is going to be very confusing. Without the education process and the regulation consultation, can you see it put into effect with any kind of clarity?

**Dr McFarlane:** Mrs Sullivan, in our presentation we stress the need for education at all levels, be it the public to educate them about the intent, the purpose, their responsibilities and rights, as well as extensive education to all levels of practitioners to have them understand their responsibilities and rights as well. So a massive education program before the legislation is put into place is our suggestion.

**Mr Jim Wilson:** I very much appreciate your brief, once again, this morning. On page 49 of the brief itself, you mention review and accountability of the Advocacy Commission. We have grave concerns, as is reflected in your brief, about the accountability of the commission. In terms of review of the commission, can you elaborate on what you mean there?

**Ms Carolyn Shushelski:** We feel there should be some kind of formal mechanism in place that could ensure that those decisions on those matters that are before the commission, at least in some public forum, can be reviewed so that we can understand exactly what matters are before it and so the public has an opportunity for that review.

**Mr Jim Wilson:** Do you envision any particular model there? Would a ministry take responsibility for reviewing? The auditor is going to review the books of the commission; that's in the act.

**Ms Shushelski:** No, we have not identified the specific model in our brief itself. I would suggest that it has to be something that can be objective and can ensure there is this objective review of the commission.

**Mr Jim Wilson:** I almost need another arm's-length body to review this arm's-length body?

**Ms Shushelski:** That was what we were envisioning.

1140

**Mr Sterling:** I'd like to say that I'm getting increasingly alarmed about the right of the advocate to this health care information. We've had it expressed by a number of groups, and I'm very much concerned about the misuse of vulnerable people's health care information and how widespread the use of that information becomes by the advocate or the commission. There seems to be nothing in Bill 74 to prevent the advocate from sharing it with all 140 other advocates. There doesn't seem to be any kind of penalty with regard to how that advocate is dealt with if in fact he shares that information with somebody else. I'm very concerned about it.

Another part I'm concerned about is the fact that we again do not have the political element from the Ministry of Health in these hearings to hear some of the most influential groups with regard to our health care system. We had, before you, the College of Physicians and Surgeons of Ontario; we have you, the Ontario Hospital Association; we have next the Ontario Psychiatric Association; we had the Ontario Association of Children's Mental Health Centres this morning; we are going to have this afternoon the Ontario Nursing Home Association. We don't have the political element from the Ministry of Health here in these hearings.

I'll tell you why it's really important in these hearings. We have three ministries involved in these bills: the Ministry of the Attorney General, the Ministry of Citizenship and the Ministry of Health. This legislation, this pack or group of bills, affects mostly the health care system. We have the Ministry of Citizenship carrying the bills, which I think is wrong, but notwithstanding that, it is here to represent its interests. How are we going to affect the decision of the government as a whole to put forward reasonable legislation when the political element from the Ministry of Health is not here?



The Minister of Health continues to say, "This should be commonsense legislation. This should be legislation which our health care professionals can put in place, where our health care institutions can put forward a reasonable program of treatment." Yet we don't have the political element here. We don't have legal counsel here from the Ministry of Health. We haven't had the parliamentary assistant for the Minister of Health here all week.

Our frustration in the opposition is that we believe that possibly we could get a good package of bills here. We're not trying to obstruct this legislation; we're trying to work towards a meaningful, workable group of bills, notwithstanding that we have some difficulty with the whole setup and the spending of \$30 million to \$40 million on an Advocacy Commission from which we don't think we're going to get good value for money. Notwithstanding that, we'd like to constructively work together a workable package, yet we're lacking the most important political element in these hearings. I think it's arrogant and I think it's distasteful that a government should hold sham hearings and not have the political element in these hearings.

To a group as important as the Ontario Hospital Association, a group as important at the College of Physicians and Surgeons of Ontario, I find as a member of this Legislature a great deal of discomfort that the end result of these four pieces of legislation is going to be more than imperfect. I think there are going to be some real disasters that result out there in the public after this legislation comes forward because this government has been inattentive and incompetent in how it's handling itself during these hearings.

I'm sorry I've used up my time, but I wanted to express that to you. You may be frustrated yourselves, but you are more kind and courteous than I as a member of this Legislature. I've got to tell you, I'm really concerned that when this legislation is done—and it's very, very complex—there are going to be some major glitches in it and they could have been dealt with if the government had been paying attention and had put its efforts and its work behind it in order to make it workable. We're really concerned.

**Mr Owens:** Before I ask my question, I would like to correct the record and I would appreciate it if this time would not be deducted from our allotment.

Mr Sterling has made a comment with respect to the non-attendance of the parliamentary assistant to the Minister of Health. This is in fact not true. The parliamentary assistant has been here. He was in attendance yesterday. He is not here today; he is off doing consultations with respect to the Public Hospitals Act.

The day before yesterday Mr Sterling again alleged the parliamentary assistant had never been here, which again is factually incorrect. We do have a policy adviser from the Ministry of Health who is quite capable in terms of answering questions.

**Mr Sterling:** He's not a politician, has nothing to do with policy.

**Mr Owens:** In terms of answering technical questions, we do have a—

**The Chair:** In fairness to our presenters, maybe we could continue with the presentation.

**Mr Owens:** My question, then, is either to staff from the Ministry of Citizenship or from the Ministry of Health. In terms of the rights advisers and what currently exists in health care institutions now, I gather they're called patient ombudsmen. How do we see that role interrelating? Will the rights adviser take the place of the patient adviser or the patient ombudsman, or do we see the patient ombudsman taking on the role of the rights adviser?

**Ms Jutta Auksi:** What you're talking about now is an implementation issue, but currently in psychiatric facilities there are rights advisers operating.

**Mr Owens:** But also in acute care hospitals; for instance, the Toronto General Hospital has what it would call a patient ombudsman who takes on the role of advocate on the patient's behalf if there are problems within that institution that the patient has identified. Will the position of rights adviser usurp or take over the position of patient ombudsman or will there be two different individuals operating within that institution with respect to patient rights?

**Ms Auksi:** This is, as I say, an implementation issue that's certainly not an obvious conclusion to draw. As you've heard in the hearings, there are concerns that people would have about conflict of interest if it's someone working within the hospital setting. So the actual development of a program of rights advisers is something that comes at the next stage, and how much rights advice would happen depends on what the limits of the role of rights adviser are. The amendments that have been put forward involve a lot less rights advice than would have occurred under the original bill, and the question, then, is how to do that in an efficient manner. If you're not going to have rights advice needed very frequently in any one place, then presumably it would have to be organized in a way that you don't have someone sitting around waiting for a call, but rather a way of plugging into a rights advice system as needed in a cost-efficient and timely way.

**Ms Carter:** With respect to Bill 74, this legislation, of course, is to empower the vulnerable—that is what it's all about—to protect them from neglect, abuse or not having their preferences respected. In light of that, I'd like to question three of the points you raised.

One is access to records. In addition to helping individuals, the advocates have the power to carry out systemic changes, and they need to access records for that reason, because they find that there's a whole group of vulnerable people who have a problem that they share because of what is happening in some institution or whatever. So I put that before you.

Regarding rights of access, the object is that the vulnerable person must be able to meet privately with an advocate. So I hope that when you say they should only enter common areas of premises and so on, you would bear in mind that this is what we're trying to achieve, and, of course, if the vulnerable person doesn't want to see them, they have to leave immediately.

Regarding the composition of the Advocacy Commission, with respect, I think if we adopted your suggestion there we would lose the whole point of what we are trying to do. The intent is to have representatives of vulnerable



groups on that commission so that it will act, as it were, from their point of view and in their interest.

Of course, as you mentioned, we do have an amendment which gives an advisory committee which will have people from families and so on represented on it. I would just like your comments on those points.

1150

**Dr McFarlane:** I'll just comment on the advisory committee and Carolyn will answer your other questions. At the moment this bill has not been formalized and we were unable to comment on that because we're not sure what its mandate will be. We're waiting for the opportunity to comment on that. Carolyn may speak to your other points.

**Ms Shushelski:** With respect to the facilities and the access by advocates to facilities, I certainly understand and respect what you're saying: The intention is to empower the vulnerable persons. The only difficulty we're having—and I'm going to speak about a hospital and most particularly an acute care facility—is that even now I think if relatives want to visit their family members there are certain hours that are restricted, and even outside those hours, at the very least they announce themselves before they enter the room, for obvious reasons. There are things of the most personal nature going on in hospitals every moment of the day and it could prove to be embarrassing or humiliating to have people just be able to walk anywhere they want.

**Ms Carter:** I question whether that would in fact happen, but if it did, maybe it would be unfortunate.

**Ms Shushelski:** I guess what we're saying is that the way the legislation is written it could happen and what we're doing is drawing that to your attention. Maybe there's some middle ground that can be reached here. What we're saying is at least we should have the ability to know that this person, who's really a stranger to the hospital and to the patients, is entering the hospital, who the person wants to see, and even be escorted to check that the patient is in a state that's reasonable to receive someone. I don't think it's unreasonable to really ask that much.

As to the records issue, our concern overall is that the records in the facility certainly relate individually to patients. There could be the patient's individual records. There are also records that are in the facility that relate to peer review, quality assurance, many kinds of records such as that. OHA and other groups, such as OMA, have argued for many years to be able to have a provision that would exempt that kind of material from access by outside bodies for the very reason that this kind of discussion, dialogue and comment that goes on within the facility is intended to promote better health care overall. If we have that material available to outside bodies, it will increase the likelihood that there'll be a reduction in the amount of discussion and overall improvement in health care. That's how part of the policing goes on within the institution. That's a reality, and those records are very important to us.

The fact that the commission has this overall ability to basically say that in that facility it believes there are vulnerable persons and you may access those certain records is the concern that we have. We've argued for a long time

and we feel now we're just gaining some ground. As the College of Physicians and Surgeons mentioned, the Public Hospitals Act Review Steering Committee is making the recommendation that peer review information will be exempt. If we override that in this legislation, it sort of takes us back to square one and perhaps makes it even more difficult for us.

**The Chair:** Mr McFarlane, Ms Shushelski, on behalf of this committee I'd like to thank you for taking the time out this morning to give us your presentation.

#### ONTARIO PSYCHIATRIC ASSOCIATION

**The Chair:** I'd like to call forward our next presenters, from the Ontario Psychiatric Association. Good morning. Just a reminder: You'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Dr Brian Hoffman:** I am Dr Brian Hoffman, a psychiatrist. At my side are Jennifer Bangay and her mother, Betty Bangay, who are relatives of a psychotic patient currently refusing treatment.

I wish to make some comments about the proposed legislation, allow the Bangay family to tell you their plight and then ask you to re-examine your proposals to see which sections will help mentally ill patients to receive treatment and which sections will prevent psychotic patients from receiving effective treatment in our society.

I am here representing the views of the Ontario Psychiatric Association, with over 1,100 psychiatrists in the province. I graduated from medical school in 1966, 26 years ago, and have had a family practice and a psychiatric practice since then. At the present time I am director of the psychiatric day hospital and a teacher at Mount Sinai Hospital in Toronto. I chair the legislative review committee of the Ontario Psychiatric Association, which is why I am here today to respond to your legislation.

I want to give Jennifer Bangay and her mother an opportunity to describe a current situation they are having with Valerie, a 28-year-old woman who is the sister and daughter of these two women with us. I first met them only last Friday, after a psychiatrist who had treated their relative had called me to ask if there was anything else he could do to get their relative help.

My image of your work is that perhaps you sometimes get bored with all the posturing, the political statements and the dogma, and you might appreciate an opportunity to look at the reality of how your work will improve the lives of many of the mentally ill and how it could prevent treatment of others.

I believe we must make it easier for the families to help their ill relatives. We are not here only to help the families of them, though, because there is no "them." We are here to help ourselves. My mother was psychotic for the last 20 years of her life until her death; I'm told David Reville's son committed suicide, and Martin Barkin's brother is schizophrenic—1% of our relatives will have schizophrenia at some point in their lives. Many more than that will



require psychiatric treatment for short or longer periods of time. We must make it easier for competent patients to make decisions about treatment before they become incompetent, and for substitute decision-makers chosen by the patient and for family members and others to make decisions for the incompetent patient.

Ontario laws for years have ignored the mentally ill and have given them the right to remain psychotic, and through legislation Ontario has guaranteed that the mentally ill will receive more rights and less treatment than comparable medically ill patients. This is especially so when the rights advisers and the advocates are hostile to the health care systems and introduce a high level of adversarial conflict to the therapeutic setting and therapeutic relationships. This adversarial approach is the only possible result if the consent legislation does not state its purpose in the preamble. That is that it is there to protect the rights of the competent patients and to ensure the treatment and rights of the incompetent patient. If this is unstated, then the advocates will of course come in thinking they are there only to ensure rights. Rights are not much good to you if you're dead and they're not much good to you if you're psychotic.

You, as politicians, are no longer on the cutting edge of legislation. Twenty years ago you were among the first to restrict involuntary hospitalization to dangerous patients. Many of the states followed on the civil rights bandwagon. We have stayed there.

Since then, over 30 states have revised their laws, loosening the requirement for dangerousness and allowing more psychiatric patients to receive treatment while ensuring their rights. In my opinion you are still in the legislative backwater by interfering with psychiatric treatment and not giving families the authority to look after their relatives, by introducing more procedural safeguards for the mentally ill than for the medically ill, as if the medically ill need protection from family and from therapists. You have not ensured that psychiatric patients receive the same rights as medically ill patients. In fact, you give them more rights and therefore less right to health and treatment.

You are moving less quickly than many other jurisdictions in the States, in Europe, and even in the Middle East. Your legislation still discriminates against psychiatric patients by giving incompetent psychiatric patients the right to thwart their treatment, even when similar patients with brain disease or incompetent medical patients would receive necessary treatment.

Let's hear from a family, a family that I've only known for five days, and then I will make a few additional comments to look at specifics about your legislation.

1200

**Ms Jennifer Bangay:** My sister Valerie was diagnosed as a schizophrenic just over two years ago. She remained untreated for one year because shortly after she was diagnosed she became pregnant and neuroleptics are not recommended during pregnancy.

One month after the birth of her child, she had a psychotic episode. She was hospitalized by the police under a form 1, reluctantly agreed to be treated, and within days she was vastly improved and able to return home.

At some time during the fall of 1991, she stopped taking the medication. Her mental state slowly deteriorated and by May, 1992, she was again seriously delusional and psychotic. My mother went to the courts to get a form 2 from a justice of the peace and Valerie was again admitted into the hospital by the police. This time she refused the medication.

After the 72-hour holding period allowed under the law, the psychiatrist recommended that we apply some pressure by giving her the choice between living at home with the medication and living on her own. Reluctantly, we agreed, naively believing that she would be provided with accommodation while she contemplated her options. Instead, Valerie was released and she disappeared.

She called us from time to time but refused to tell us where she was. Two weeks later she wandered home and my mother allowed her to stay at home while she decided which option to choose. She again became delusional and psychotic, phoned 911 and told the police that I was feeding her baby cocaine from a popsicle stick. The police came, quickly understood the situation and tried to get Valerie to go to the hospital. She refused and again left the house.

That night, although we didn't realize it at the time, she slept outside underneath my mother's bedroom window. She hung around town for a few days, then disappeared into Toronto and we have not heard from her since. She is, however, in regular contact with the minister of our church. He is her last link to our family.

I'd like to give you some background. Valerie stood at the top of her class throughout public school and high school, and I mean at the top of her class. She trained in gymnastics with the Winstonettes at the time they were being coached by members of Canada's national team. She held summer jobs, she dressed well, she had a boyfriend.

After completing high school in four years instead of five, she went to the University of Toronto to study sciences and, despite the onset and development of this illness during her university career, Valerie graduate in the top 15% of her class.

During university, Valerie began to have unexplainable outbursts of anger, which occurred more frequently as time passed. As she became more abusive, her social and her family life became unpleasant, which compounded her discontent. She began to tell lies. Her arguments became more and more annoying to others, because as the illness progressed, she lost the ability to articulate in a logical process of thought. Her self-esteem suffered one blow after another as she lost the ability to maintain personal relationships, and she began to sleep an inordinate amount of the time, I believe from depression. Meanwhile her stories become ever more dramatic.

When she began to have psychotic episodes, drugs became her rationale. She missed an exam and explained this by telling us that she had seen the professor doing a drug deal and he was out to get her. She claimed he later put drugs in her drink while she was at the pub. She paid some con artist \$750 because he told her he would protect her from "them." Two days after attending a party, she claimed she had been forcibly injected with drugs, but she was at home the day in between and she was fine. She was



accepted into teachers college in Edmonton but was asked to leave after accusing one of the individuals under whom she was practice teaching of being involved with drugs. Throughout her pregnancy, Valerie was obsessed with the idea that she had AIDS and herpes and that the baby would also contract them. More recently, she has registered complaints with the police about drug deals she has witnessed and restaurants where she got food poisoning. With drugs as a running theme in her illness, is it surprising that she won't take the medication she so desperately needs?

My family has an endless list of worries, and I'd like to tell you about four of them.

1. When Valerie accuses me of feeding her baby cocaine, I understand that she is ill, and although it hurts to have her stand and tell the police and accuse me of having already been in jail once for trafficking, I would not press charges against her. Other people may not react the same way. We are afraid Valerie is going to find herself in court under mischief charges, defamation of character charges, damages to business charges. The courts will treat her as if she's normal. The teacher in Edmonton threatened to have her charged, and no wonder. Can you imagine the effect that accusation could have on his career?

2. Valerie's life is full of delusional terror and bitterness because no one will help her to prove that she has been a victim of crime. Her range of emotion when not psychotic is flat and depressed. She is always sad and convinced that the worst is happening. She gets no joy from her life, not even from her daughter. Her intellectual potential and desire to contribute is being wasted and frustrated, and her chances for a normal life with normal relationships are becoming less possible as more and more of her acquaintances realize that she is mentally ill.

3. Valerie's daughter, who is the light of my life, is, thankfully, blissfully unaware of the problem right now, but as she gets older, we worry about the impact on her.

4. Valerie's illness has consumed my family for the past two years. We are all victims of her illness. My mother is terribly fatigued. At 65, she is the main caretaker of Valerie's daughter, but the care of the baby is nothing compared to the stress my mother is under in trying to care for Valerie, who requires far more of her time and energy than the baby does.

I have some problems with the way human rights are being applied to the mentally ill, and I'd like to give you an example to explain that.

My neighbour also has a sister who is mentally ill. Thankfully, she is under treatment. She told my neighbour that when she was ill, her mind worked on two levels. On the first level, she was angry, and this anger was projected to the outside world by abusing, accusing and blaming her family and others for her delusional problems. This level was unable to articulate the real reasons why she needed help. I believe that this is the level that is causing Valerie to refuse her medication.

The second level knew the first level was bizarre but couldn't prevent it from saying all the hurtful things. This second level suffered from auditory hallucinations, causing her to believe that she had told her family about her illness and her need for help, and at this level of understanding

she could not comprehend why her family would not help her. She felt that no one cared enough about her to help her. I have lived with and watched Valerie for five years, and I believe that she feels this way too.

1210

How do you apply human rights legislation in a case like this? Is it only the level that screams at the outside world that is heard? What about the silent level that the patient thinks she has projected? Will it never be heard?

My family is a close but not a suffocating family. We do not want to control Valerie's life. We do not want to control her finances. We don't want to control where she lives. We know from our experience in living with her that the more normally we treat her, the more normally she acts when she's not psychotic. We do, however, want to help her to live as full a life as possible.

We feel that under the current law, it is preventing us from helping Valerie's second level of thought have its say. We are frustrated and angry that someone with so much potential and a beautiful daughter to care for is being prevented, by an intrusive law, from being helped.

My brother, my sisters and I have discussed the fact that this is a genetic illness; it's "There but for the grace of God go I." We all agree that if we were Valerie and Valerie were one of us, we would want her to do everything in her power to help us to lead as normal a life as possible. We keep asking ourselves how a cold, distant law can take precedence over the collective wisdom of her family. We are the ones who love her.

Please, before you make the final changes to these laws, make sure you consider the terror and unhappiness of the untreated schizophrenics. Make sure you consider the impact they have on their families and on their community and make sure you consider Valerie's silent voice. Thank you.

**Dr Hoffman:** This patient has schizophrenia. We believe it is largely an organic or physical illness. It is not caused by unemployment or poverty. Such patients drift down to unemployment and poverty. It is not caused by the family or family disruption; not in this family and not in the Sabatino family, where Dominic was shot just two days ago, and not in other families.

Tomorrow you will hear a joint presentation led by the Ontario Medical Association in conjunction with the Alzheimer Association, the College of Nurses, the College of Physicians and Surgeons, the Ontario Friends of Schizophrenics, the Ontario Hospital Association and the Registered Nurses' Association of Ontario.

We have read their submission and agree with the many questions they have raised: The powers and lack of accountability of the advocates, their wish to restrict rights advice to the incompetent patient when there's a controlled act, rather than defining settings and the lack of substance to the definition of "patient wishes."

However, as a psychiatrist I want to underline and look at this family—two or three specific points that pertain to psychiatric patients. On page 22 of the submission you will have tomorrow, or maybe already have, that conglomerate of diverse groups points out how the emergency admission



procedures discriminate against psychiatric care. Tell this family that you're going to discriminate against psychiatric patients by not allowing an admission, even if a medical patient with similar symptoms would need admission, someone with multiple sclerosis, someone with a brain tumour. Tell this family that you're leaving the law as it is.

On page 26 they discuss how the advance directive of competent psychiatric patients can be thwarted when they become incompetent. Tell this family that you're going to allow psychiatric patients, when they're incompetent, to thwart their own advance directives, but that you don't plan to do that with someone with a physical condition.

Many coroners' inquests have come to the same conclusion. They have to know what a coroner's inquest is. It's an investigation into a death. The findings are made by a jury. The jurors are laypeople. They hear the evidence and they come forward with recommendations. Inquest after inquest of impartial jurors has said: "The laws interfere with the treatment of psychiatric patients. They interfere with the rights of families to look after their ill. They don't define their purpose."

I refer to the death of Hendrick Looman in November 1989, Margaret Miller in August 1989, Paul Pendock in March 1989, Timothy Gamble on November 22, 1989, Stella Lacroix in 1989 and Ronald Davies in 1989. One, two, three, four, five, six coroners' inquests in a single year, and all of their requests have been ignored despite their impartiality and a consistent thrust to ask for more authority and responsibility for the family to look after their ill and for better laws to allow the treatment of medically ill, and this can be done without encroaching on their rights.

I have told this family, in my one interview with them, that they may be able to get their relative some help, some treatment, a year from now when these laws are passed.

There are changes that you're making. Some of the strengths are: the definition of competency; the use of advance directives, including powers of attorney, a clear list of substitute decision-makers including guardians under the Substitute Decisions Act, patient representatives appointed by the board, other family members and finally the public guardian and trustee, who can all act as substitute decision-makers; the principles of substitute decisions; the improvement of some emergency provisions, at least for the medically ill; and the notification of rights advisers in some settings and with some procedures.

I have also told this family that they may not be able to get their relative treatment where they would if the patient had a medical illness because these amendments do not really address the need and the right of the incompetent psychiatric patient to receive treatment and the right and the responsibility of the family to the patient after the rights advisers and the lawyers have gone home. This is a family that wants to look after its ill. The Sabatino family wanted to look after its member. What do we give these people in our society? We give them streets; we give them bullets; we give them suicide as an option.

One of the weaknesses in the legislation is the lack of relatives on the Advocacy Commission. How can you have incompetent psychiatric patients on the Advocacy Commission? Obviously you can't, so who's going to represent

them—less ill people or perhaps people who have never been schizophrenic or people with other forms of mental illness who don't know what it's like to be incompetent but know what it's like to live with? You're telling these people, "You're not needed on the Advocacy Commission." Yet where do you want the patient to go when treatment fails, to the lawyer's office or home?

**The Chair:** Excuse me, Dr Hoffman. Our half-hour is almost up, so if you could wrap it up, please.

**Dr Hoffman:** Okay. Other weaknesses are: advance directives can be appealed by the incompetent psychiatric patient but not by other patients; the restriction of psychiatric admissions and treatment in an emergency setting under subsection 22(9); restrictions to a psychiatric admission if a psychiatric patient objects. Will their relative object? Of course. Notification of a rights adviser and an adversarial tenor is immediately sent when a psychiatric patient is found to be incompetent in a setting, even if a controlled act is not being prescribed. You always introduce an adversarial role into the psychiatric setting with the incompetent patient which you do not introduce with other medically ill patients under the current proposals.

Last, the patient's wishes when competent would be very hard to determine. It is likely that the vague and fuzzy wishes of their daughter when she's incompetent would be confused but would be convincingly argued by the patient's lawyer and advocate, thereby preventing treatment.

I end my presentation and ask you to ask questions.

1220

**Mrs Sullivan:** This has been a very poignant brief for us, because it really does bring the reality of the schizophrenic patient living within a family who is seeking treatment for that patient. I am quite concerned, and actually it's an opportunity for us to raise subsection 19(2) of the Consent to Treatment Act, which it seems to me provides an incorrect impression that a substitute decision-maker under the Consent to Treatment Act will be able to consent to admission to a mental facility, a psychiatric facility. In fact that's not the case, and we will have to have an amendment to that section, and I don't think this has been raised before in committee. I think Bill 108 has it correctly under section 56, but Bill 109 is quite incorrect in 19(2) and will continue to be incorrect even with changes in the law, and I hope that will be taken into account. Other than to note that, I don't have questions.

**Mr Joseph Cordiano (Lawrence):** I just wanted to make a brief comment. I am a substitution on this committee, but I just wanted to say that obviously this is an issue I've come in contact with on a number of occasions with constituents in my own riding. I know what you've said here today is increasingly important and is very touching to me personally, because I've heard these pleas from a variety of people in my riding, both personal friends and others who suffer similar circumstances.

Being only a substitution on this committee, I think I would ask members of the committee to look at what you've said very carefully, to listen to those concerns, and I know that in my capacity as only a substitution here this week I would make that endeavour to look at the sections



which apply to those aspects of the concerns you've raised today. Having been the critic at one time for this area, when this legislation was introduced we raised these concerns as a party at that time. I think further work needs to be done in this area in these pieces of legislation to look after those very, very poignant matters you've brought before us today. Thank you very much.

**Mr Sterling:** I'd like to thank particularly the family for coming forward. I know it must have been very difficult for you to do this in front of a legislative committee. We have had other families in front of this committee.

I think that from our point of view, Mr Wilson and I from the Conservative Party have recognized that there is a significant problem with this particular mental illness and governments in the past not dealing with it. We only feel that, in terms of our bias at this point in time, we would be very much more prone to the right of a psychiatric patient to treatment rather than the right to consent to treatment.

We believe, I think, that with this legislation in the Advocacy Act, the culmination of these acts leads the health care provider to the conclusion that there is an adversarial process which is being set up under these acts, which we disapprove of. We basically trust health care providers in terms of what they have done in the past for various patients, either in a psychiatric setting or a medical setting, and this legislation calls into question the integrity of health care professions and unnecessarily so.

I am frustrated, as Mr Cordiano is, from time to time when I have mothers and sisters of schizophrenic patients come into my riding office, which I had two weeks ago, telling a similar story as to how they can help or cannot help their family members. I believe the law has to go even further than some of the few helps in Bill 108 to deal with this problem. I believe that should we get another opportunity to come back to government then we would strengthen the hand of families in dealing with, in particular, schizophrenic patients, because I believe it is a different disease, it is a different illness and perhaps we need some specific legislation to deal with the treatment of these individuals in our society.

It's also very costly for our health care system to maintain its present blindness to the disease. I just wanted to let you know that we will be fighting, in terms of the amendments, for some of the suggestions you've put forward to this committee.

**Mr David Winninger (London South):** At the outset of your presentation, which I thought was very moving, you indicated that there was a lot of political posturing that went on that you detected. Unfortunately that's often all too true as politicians descend into the arena and sometimes take cheap political shots, but hopefully we can ignore that kind of posturing and get on with the necessary changes that have to be made.

I, like you, have a family member who's schizophrenic. I know Mr Wilson has said on the record that he does too. I have a brother who was at the top of his class, well socialized. All that changed overnight when he was 18. He's become withdrawn and is very maladapted.

Fortunately there are some changes that are being introduced with our legislative package that change our ability to afford the necessary treatment to schizophrenic patients, such as you describe. At the same time that my family has an interest in seeing that my brother receives necessary treatment, I am interested that his civil rights are respected and complied with. I think there's a very fine balance between the need to treat and the need to respect and affirm a patient's rights.

Under Bill 108, the Substitute Decisions Act, there are changes that will be implemented that will make it a little easier, perhaps, to treat a non-compliant psychiatric patient. I allude to the expedited validation of powers of attorney; I allude to guardianship, whereby a guardian can make a decision to admit a patient and to have a patient treated, and that's deemed to be voluntary.

Furthermore, as a result of numerous submissions that were made detailing the plight of a psychiatric patient who realizes and acknowledges that there may be times when that patient lacks the lucidity to consent to treatment but would later, after receiving the treatment, admit that it was very helpful to have that treatment and to stabilize him or her, we've introduced an amendment, which we call the Ulysses clause, which allows a specialized power of attorney to be drawn directing an attorney to make those kinds of decisions.

So I think this government has gone a long way towards obviating the kind of difficulties that you expressed today, because this revolving door of psychiatric patients going in and out of treatment and the difficulty that people like you encounter when you try to get an order from the justice of the peace for treatment, a form 2, is well documented. So I don't think it's quite fair to say that no changes are being made to meet the concern, and I particularly took umbrage when you suggested that we're not responding to the needs of these vulnerable people. I give you the recent example of the setting up of the Lightman commission, an investigation into the kind of abuse that goes on in unregulated boarding homes. We really have to be sensitive to the stories we've heard, in the initial stage of these hearings, from psychiatric survivors who have encountered all kinds of abuse within the system.

While I applaud your efforts to improve and ameliorate the condition of your family members, I also think we have to be very careful in how we go about that so that whatever changes we invoke we're still respecting their rights as individuals and their human dignity.

**The Chair:** Thank you, Mr Winninger. Dr Hoffman, Ms Bangay and Mrs Bangay, on behalf of this committee I'd like to thank you.

**Mrs Betty Bangay:** May I say one thing? You're going to have to hurry your laws up, because a lot of people are going down the drain while they're waiting for you to dither along and take one little step at a time. It's only common sense: A schizophrenic in a psychotic condition is completely irrational, and it's common sense that an irrational person cannot make a rational decision. A rational decision is to be helped, and that's what I want you to think



about. I think it's about time that you stopped dilly-dallying around and got to work and got it cleared up. That's the point.

**Mr Winner:** Just one point: Some of the changes you're asking for are also being considered in our review of the Mental Health Act, which is a separate review from the one we're involved with today, admissions to psychiatric facilities.

**The Chair:** Thank you, Mr Winner.

**Mrs Bangay:** I hope you'll do your very best.

**The Chair:** Once again, on behalf of this committee I'd like to thank you for taking the time out and giving us your presentation today.

This committee stands recessed until 1:30 this afternoon.

The committee recessed at 1232.

## AFTERNOON SITTING

The committee resumed at 1351.

## ONTARIO NURSING HOME ASSOCIATION

**The Chair:** I would like to call this meeting back to order. I'd like to call forward our first presenters from the Ontario Nursing Home Association. Good afternoon. Sorry for the delay. As you know, you'll be allowed a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Ms Deborah Wall-Armstrong:** My name is Deborah Wall-Armstrong. I'm a vice-president and board member of the Ontario Nursing Home Association. I'm also a lawyer and I represent the owner of a 110-bed nursing home in Barrie. With me today is Fran Bouchard, a registered nurse and the administrator of that same home. Mrs Bouchard has worked directly for many years with long-term care residents before assuming her administrative duties. Our role here today is as spokespersons for the members of the Ontario Nursing Home Association.

These members represent almost 300 nursing homes in Ontario which provide care to over 27,000 seniors. We have outlined in the past to this committee a profile of our residents which bears repeating. This information was the result of a randomly selected survey of 50 nursing homes done for a director of nursing consensus conference.

The outline indicates that 75% of our residents are moderately to severely cognitively impaired. This means they have difficulty making decisions. They're not oriented to time, place, person. They are unable to form judgments. They're unable to follow instructions and their memory is impaired. They're not capable of learning new skills or information.

Thirty per cent of our residents are immobile, requiring total assistance of one or two persons to move. The remaining 70% require some degree of assistance with mobility.

Fifty-four per cent of residents have behavioural problems, such as aggression, wandering, screaming, hoarding. Eight per cent of residents are unresponsive in that they are unable to communicate either because of physical problems, such as a stroke, or they're semi-comatose. Sixty per cent of residents have difficulty communicating because of psychosis, aphasia, language barrier or an inability to transmit or understand communications. Twenty per cent of our residents have no family or next of kin.

With the proposed changes resulting from the redirection in long-term care, we will see an increase in the number and severity of resident cognitive impairments. This means that theoretically 100% of the residents will require substitute decision-makers for personal care eventually. More residents will have aggressive behaviour problems. These behaviours impact on the rights of other residents and we can foresee an increase in advocacy service to determine which residents' rights will prevail.

In general, all care levels will increase and there will be less family involvement and support. Those with family support are expected to remain at home.

As you can see, our sector is anticipating a major impact by these pieces of legislation right from day one. All our residents fall under the definition of "vulnerable," and many thousands are "incapable" as to person and property. At present, our staff and physician advisers work comfortably within the boundaries of common practice guidelines to care for residents in a fashion that they feel does not expose themselves as care givers to significant liability.

This package of legislation, while recognized as needed, strikes fear in the hearts of many of those care givers. In our ever-increasingly litigious society, that fear spells a real threat to the care of the residents. Individuals who have to respond to resident needs will become unsure of their right to act or disagree about the technical requirements.

Avoiding these glitches will be critical to the quality of care and even the lives of thousands of our residents. The most acute time will be in the initial days, weeks and months of implementation. If we have the bogged-down effect that has happened with some acts—and what comes to mind is SCOE, support and custody order enforcement—then we see ourselves having to face crisis management and unnecessary threats to lives. None of us wants that. You don't want it; we don't want it.

We were pleased to see the many extensive amendments which the government has already introduced; however, there are many substantive and technical issues that continue to be of concern to us. We've given you our paper and time does not permit me to read the whole of the paper. I would ask that you please read it carefully because we do make several comments there on certain key considerations. At this point I will just review certain ones.

Our association was a member of the ad hoc committee that presented yesterday and we endorse all the recommendations of that committee's report. Of special concern to us are the general needs for checks and balances for the Advocacy Act.

The things that are recommended deal with giving vulnerable individuals the right to challenge the finding of "vulnerable" if they oppose its implications, providing an accountability of the commission and advocates, looking at a need for a natural justice provision to apply to the commission's dealings with facilities or organizations, establishing an appropriate infrastructure, and last but certainly not least, limiting the advocate's right to warrantless entry.

We treat and usually are encouraged by government to treat our facilities as the home of our residents. Their rights to privacy should be respected as much in a nursing home as in their own home, and we see no need to diminish their right to privacy by virtue of their mere need to live in a long-term care facility.

In Bill 109, I want to particularly draw your attention to the section in our paper dealing with the definition of



"treatment." We find that the definition of "treatment" is so broad that it will affect virtually everything we do with residents and consequently tie us up in a continual bureaucracy of obtaining consents.

We recommend that the legislation recognize the use of care plans that are used in long-term care facilities. If I can take a moment just to highlight from our brief, we feel a more effective definition for residents in long-term care facilities would be to allow a blanket consent upon admission for the care plan which outlines the day-to-day nursing and personal care, social and restorative, spiritual and recreational activities. Only physician-prescribed procedures that are invasive or that do not happen on a regular basis should be subject to a separate consent.

We therefore recommend that section 1 dealing with definition of "treatment" in Bill 109 be amended to read: "In long-term care facilities, a plan of treatment shall not include a plan of care which outlines the day-to-day nursing and personal care, social, restorative, spiritual and recreational activities, if it's been consented to by the individual or their duly authorized substitute decision-maker as to person. The plan of treatment does include in long-term care facilities any prescribed procedure by a health care provider that's invasive or does not occur on a regular basis."

We'd also recommend that a transitional provision should also be considered for a specific time, allowing care providers to rely on pre-existing plans of care in the case of those incapable residents who are in existence at the time of implementation of the act. This would dramatically ease a concern we have about transition and allow for the required time for the appointment of substitute decision-makers for care for thousands of our residents.

We know, practically speaking, that even right now, when we need to have the public guardian step in to even deal with procedures for palliative care for dying patients when there is no next of kin, that procedure takes four months, as it stands at the moment, and if they're going to be potentially thousands of applications, we have no idea how long it would take for us to get those decision-makers in place who would be needed from day one.

1400

Many of our concerns about Bill 109, we feel, could be dealt with successfully by an implementation task force. Those concerns include the sections in our paper dealing with evaluating capacity, "emergency treatment" definition, the concept of global incapacity, statements by family members, and other implementation concerns that are highlighted.

In Bill 108, I specifically want to draw your attention to our concerns about subsection 65(2) dealing with "change of person's residence." This is an area that very much concerns, from a practical standpoint, the people in the nursing home industry, in that it deals with the requirement, before changing an incapable person's place of residence to a more restrictive setting, to outline requirements, to notify the public guardian and trustee of the incapable person and others, or involve the courts on an application to authorize the change.

We've had discussions with ministry staff, who have indicated that they interpret that the movement between types of living environments, as well as moves within an environment, will be deemed movement to a more restrictive setting. We find that this seems to be an unreasonable request and may delay required care.

It's important to note in here that what we're talking about is that the majority of moves for a more restrictive setting in our sector are based on care requirements. For example, if we have an aggressive resident who needs to be placed for his own safety or the safety of others, he can't wait for days for bureaucratic decisions to be made; otherwise it is likely to cause injury either to himself or certainly others around him.

Further, we anticipate that there will be a large number of applications under this section. We aren't sure whether it would overwhelm the system itself and cause delays in processing the applications for transfer. We would ask that you consider that it be more appropriate to have a review of the decision to move, after the fact, should the incapable person appear to be dissatisfied or not appropriate for the setting.

As you can see, my comments earlier on about the resident's profile would indicate that this kind of problem with aggressive residents will only increase with time.

In summation, I want to point out that our members are totally regulated in regard to funding and we have for many years had to deal with underfunding, so any cost to our facilities to provide the education to staff will need to be appropriately budgeted for by government. I'm aware that the long-term care reform funding does not have provision for this extra cost factor at the moment. New money will need to be committed for it.

We cannot stress to you enough the need for a practical and thorough approach to implementation. Serious problems in implementation could cost some of our residents their lives. We feel the best protection for the public will be the education of both the public, those in the new advocacy infrastructure and the care providers in advance of implementation.

**Mrs Fran Bouchard:** I would only like to add one comment, and that is, that as a front-line member of the care team, I can't emphasize enough the importance of a well-planned implementation of this legislation, so that we can continue to provide care for the residents who are entrusted in our care.

**The Chair:** Questions and comments?

**Mr Jim Wilson:** Thank you very much for your brief. You are correct in stating that a number of these concerns have been mentioned in previous briefs. Please be assured that we want to be as helpful as we can on many of the recommendations that you have made. I think many of them are very good.

There is one here, though, I just happened across that I hadn't really noticed before, and that was that you mention on page 20 of your brief, point 13, about advisory physicians and the requirement now for nursing homes to have an advisory physician. Is there a difficulty now, as you state, in getting advisory physicians? I think you made an



excellent point, that with the added burden this legislation creates, that could even more difficult without some sort of financial compensation built in.

**Mrs Bouchard:** It's very difficult. We are currently fortunate to have an advisory physician, but he himself is having some serious concerns about the legislation which is coming, because it's going to make it much more difficult for him to even see a resident to do an admission physical.

**Ms Wall-Armstrong:** In our particular home that we're dealing with, we have a significant number of individuals who would require a substitute decision-maker and they are not readily available. He anticipates some really serious implementation concerns.

But it's a chronic problem across the industry, not just with our home, just because of the paperwork involved currently under the Nursing Homes Act, and I know under the reform for long-term care and the funding formula that part of that is being looked at for existing problems, but there are no additional funds that are being put in here that we're aware of to deal with what we would anticipate to be an increased burden to the physician advisers.

**Mr Jim Wilson:** A hypothetical question really that asks for some speculation on your part, but when I had the opportunity—it wasn't in a nursing home specifically; it was homes for the aged in my riding as recently as two weeks ago—to explain to the residents there because I was asked to come in and speak on this legislation, I found little or no support for it when I explained it, and we had someone else from sort of the other side to explain it.

As we've heard in a lot of these submissions, people were more concerned about resources and services than they were about rights. Now maybe this is an exceptional home. I don't really think it's exceptional other than my aunt is head of nursing and I know they get exceptional care there, but there were no complaints. I'm in there regularly to give plaques to people for their 90th birthdays and that sort of thing. Do you think that your residents are really crying out for the type of advocacy services that are envisioned here and that encompass nursing homes?

**Ms Wall-Armstrong:** From our standpoint, we don't see it as a major problem or concern. Our residents, particularly in nursing homes, are more interested in care and in the care that's going to be available. I mean, it's part of the reason that you had the whole issue raised about the funding issue in the nursing homes themselves and the amount of moneys that were available just for resident care. That was sort of their first priority ahead of that—

**Mr Jim Wilson:** It's much easier to envision the need for this legislation in psychiatric facilities and when you're dealing with psychiatric patients than it really is in terms of nursing homes, so I appreciate your comments there.

**Ms Wall-Armstrong:** They're really more interested that the nursing home be a home-like setting and that the care be there in a home-like setting as much as possible.

**Mr Winninger:** I think it's acknowledged by most people that there are homes that provide extremely good quality nursing care, and I don't think anyone intends any legislation that would take away from the ability of good

nursing homes to provide quality care, but there have been well publicized instances of abuse or neglect or exploitation.

I'd be a little concerned about a blanket clause on admission that a patient would sign that would enable a nursing home to conduct a plan of care in perpetuity, as it were, because that's what would happen if you would restrict the definition of treatment to just invasive treatment by physicians.

You could have a patient admitted to a nursing home with a plan of toileting, for example, but then let's say the patient becomes incontinent. There have been examples I've read about in which nursing home residents have actually been strapped down on beds, just because they happen to be incontinent, to keep them in place. That sort of change in a regimen of nursing care wouldn't attract the kind of attention perhaps it should if we were to adopt your narrow definition of treatment. That's just one example.

1410

**Ms Wall-Armstrong:** Currently nursing homes are one of the most highly regulated and highly inspected facilities. There's no question that there's abuse. There's abuse in any process, in any situation. However, considering the amount of regulation in nursing homes and the amount of inspection that is currently being done, I really question whether this legislation itself is going to be any more helpful.

I would really question that the challenge to—from the residents' standpoint themselves, whether on the other side you have several people who, if you want to change toileting, if you have to change them, you have to obtain their consent every time and you get tied up in that bureaucratic process, whether you may not cause more problems in that particular one because just changing an individual who becomes incontinent by definition is a treatment that requires consent. If that person is also incapable, virtually you could see, from a technical standpoint, somebody saying, "You have to have a consent every time you want to change them."

**Mr Winninger:** I guess it's a matter of degree. I'm not saying every day you need to invoke an advocate and these heroic measures. All I'm saying is that if there's a substantial change in what constitutes treatment, you shouldn't have a blanket clause that the nursing home can rely on that would preclude access to the kind of advocacy that people outside the nursing homes would be entitled to.

**Ms Wall-Armstrong:** If you notice, though, when we talked about that, the care plan had to be agreed to by the individual. If there was a concern, for example, in toileting and individuals are capable, then they can require a change to their care plan. If they're incapable, they would then have a substitute decision-maker who would be required to make that change. They also still have availability to advocate services and, if they felt they weren't being dealt with on it, the advocate could question the challenging of the care plan as well.

That doesn't preclude the involvement of an advocate on there. It only deals with a practical solution to having to get consent for everything you're doing from changing a dressing to changing somebody's diaper, any kind of care



like that on a day-to-day basis that could involve many times a day getting that consent, particularly from an incapable person. We're not trying to remove their ability to get assistance if they're not being cared for properly.

**Mrs Bouchard:** I would also like to add that the care plan is an evolving process. The care plan is not only devised by the members, the nursing staff themselves; we include the residents and the families, whoever has a particular interest in that resident, to help us develop and change the care plan as things progress.

**Ms Wall-Armstrong:** Care plans have been very well used in long-term care facilities for a long period of time. There is a multidiscipline plan that is developed on it. It isn't just the nursing home or any long-term care facility that makes up the plan without consultation from many parties.

**Mr Winninger:** All I wanted to add is that the nursing homes and residents I've talked to must be different from the ones Mr Wilson has consulted with because they welcome the changes that we've introduced.

**Mr Owens:** I just had a quick question around your concerns with respect to change of residence. Could you maybe explain that a little bit more?

**Ms Wall-Armstrong:** Around the change of residence, a good example might be a nursing home that's set up almost in an apartment-style building. Usually your most mobile and your cognitive residents would be on the main floor, giving them easiest access to outside. If you have people who have advanced Alzheimer's or you have aggressive residents, you may have actually a particular floor that they are on that the staff are aware that these people have these problems.

**Mr Owens:** Generally described as a locked-in unit, I guess.

**Ms Wall-Armstrong:** No, you're not allowed to do a lock-in. It's not a locked-in unit. But if they're up on the second floor, it may be easier to catch somebody who has Alzheimer's and who is a wanderer and stop him from leaving the building. They are already on, say, the second floor of a building as opposed to being on the ground floor. That might be one good example of that change in location.

Some homes don't have that tiered level at all. It may be that for them it's easier to have all of their wanderers in a particular wing. But you still cannot lock in. You don't have a locked-in unit. You're not allowed to. Certainly our regulations don't allow for that.

**The Chair:** Ms Wall-Armstrong, Mrs Bouchard, on behalf of this committee I'd like to thank you for taking the time out this afternoon and giving us your presentation.

#### ONTARIO PSYCHIATRIC SURVIVORS' ALLIANCE OF METRO

**The Chair:** I'd like to call forward our next presenters from the Ontario Psychiatric Survivors' Alliance of Metro. Good afternoon. Just to remind you that you'll be allowed up to a half-hour for your presentation. We would appreciate it if you'd keep your remarks to about 15 minutes so we'll have time for questions and comments from each of the

caucuses. As soon as you're comfortable, could you please identify yourself for the committee and then proceed.

**Ms Shoshannah Benmosche:** I'm Shoshannah Benmosche', again presenting for Metro OPSA, Ontario Psychiatric Survivors' Alliance.

We would like to thank this committee for this opportunity to respond to the progress you have made with respect to the advocacy legislation package. We feel that you have heard us, that the legislation has been improved by many of the changes you have made and that you have not forgotten why and how urgently we need this legislation. Thank you. Please press on and put it forward. It is already in a form that substantially meets our most critical and urgent needs.

For our part, we recommit ourselves to continuing to assist you in its ongoing perfection by providing feedback on the impact it is having on us. We are encouraged by your response and will provide this feedback as long as it is welcomed and received with an open mind and an open heart. Communication seems to flow freely when its results are mutually beneficial, when communication takes the form of a lateral, even-handed dialogue, however peculiar and democratic this concept of partnership may seem to some mainstream mental health practitioners when scuttling to implement the Graham report in time for the next budget.

Our support for and our suggestions regarding the amended proposals in the advocacy package have been comprehensively addressed in both of the submissions made by the Ontario Advocacy Coalition. Our mother organization, OPSA, is a member of the coalition and our membership's views have been consistently represented at OAC meetings. We have only one correction to make to their August 6 written presentation: on the suggested wording for section 3 of the Consent to Treatment Act, the words "prevent...serious harm" should be corrected to read "prevent...serious harm."

We will therefore use the remaining time allotted to us in an effort to enhance your personal appreciation of the one most serious flaw we have found in the package. We think that clause 56(4)(c) and clause 56(6)(b) of the Substitute Decisions Act, 1992 are contrary to the Charter of Rights and Freedoms.

Long ago, corporal punishment, notably the use of the yardstick in elementary schools, was legal and practised on offending students in Ontario for their own good. We have outlawed the practice in favour of more humane encouragement. This standing committee has been advised by experts of every persuasion. Their opinions are at variance. However, we are grateful that schools no longer beat our children into submission.

But the legislatively sanctioned use of cattle prods on certain groups of people somehow managed to sneak its way into this proposed legislation which is purportedly designed to protect these very persons. We have been enlightened by professionals who only use these electric shock devices for educational and therapeutic purposes. What a relief. Ontario is the only province in Canada to embrace this practice. That's a relief too.



We leave it to the members of this committee to decide if they would like history to remember them for deciding that cruel and unusual punishment, referred to as "aversive conditioning" in subsections 56(4) and 56(6) of the Substitute Decisions Act, 1992 ought to be permissible anywhere in Canada. We wonder how it crept into the legislation. We and other caring people would like it removed. It does not belong in this legislation.

1420

Let us take a closer look at aversive conditioning, sometimes referred to as aversion therapy. As a point of clarification, "aversive" refers to the arousal of deep-seated dislike for something. To induce a state of aversion in the patient or inmate, the therapist must incite feelings of fear and repugnance excited by something offensive. It is difficult to receive this as a gift of love. The point at issue here is whether lawmakers should allow therapists or educators or trainers unrestricted freedom to choose the methods by which they bring their subjects to such a state of fear and repugnance. The condition of someone who is experiencing anger is not bettered by adding fear to their experience. Nor is the condition of someone experiencing confusion or difficulty in expressing themselves in ways we can understand improved in a context of fear, hatred and futility.

Aversive conditioning is referred to by some as therapy. Others call it torture. This is usually when it is used in another country, or in a less humanitarian context than Ontario's care facilities. We are sure of that, most of the time. It is happening now, as we speak, in Ontario homes for the elderly, group homes for children, on psychogeriatric wards, and in institutions for the developmentally handicapped. It is used to punish and control by imposing conditions of fear, through the use of instruments of torture such as cattle prods.

We are not comforted by the knowledge that such practices may not be redressed when 20 years from now the results of our continuing neglect are shoved under the nose of public scrutiny at the whim of the media. In the event this legislation is not passed now, we will again be forced to content ourselves with periodic public inquiries into the abuses of the next "20 years ago," perhaps in perpetuity.

While debating the humanity and efficacy of controversial therapies is perhaps beyond your mandate, we submit that giving such practices the misinformed blessing of this standing committee is contrary to the intent and purposes of this legislation, which is to protect vulnerable persons from abuse and neglect.

We made an attempt to obtain and present a cattle prod for the examination of this committee in order to accelerate the learning curve and to elevate our discussion beyond the abstract baffle of experts, and to inform us all, in concrete terms, of what we are talking about. However, when we used the words "learning curve," "cattle prod," "personal experience," and "informed consent" in the same breath, the prospective lender of this loathsome device became worried that it was our intent to use it on the members present.

The owner of the cattle prod was obviously unaware that we are opposed to the use of cattle prods on any

human being, including elected politicians, who would be subjected to mind-controlling drugs if a past president of the American Psychological Association had his way. We find his expert opinion unjustifiable and wish to lend it no credence. We hope the members of the committee agree and join us in our ethical and practical rejection of this repugnant idea.

We realize this is a logical leap and may seem akin to comparing apples and oranges. However, justification for the use of mind-controlling drugs and electrical shocks spring from the same ethical basis, and one of them was advocated by the eminent psychologist for use on you. Both are repugnant. Both produce desired effects for very limited duration and must be repeated unto death, and both purport to help an individual and society by the use of harmful and brutal techniques for our own good.

You, the members of this committee, are proposing to permit a judge to order repulsive acts to be performed, for example on your young niece, or the old woman who sleeps underneath Nathan Phillips Square, or the little girl who lives with her abusive, alcoholic father in Thornhill.

A judge will be conferred, by you, the power to order dehumanizing treatment, a coercive act against the wishes of a vulnerable child or adult that few people in this room—even, we hope, few judges—would find permissible under any circumstances were they forced to be present or a party to its perpetration. No legislator, no judge, no substitute decider is likely to seek out opportunities to participate in brutal acts of torture, unless they are themselves brutalized or sadists; nor is it required by the Substitute Decisions Act, 1992, that their consent be free or even that it be informed, either by personal experience directly or indirectly.

We are aware that cattle prods are presently employed in many Ontario care facilities, and routinely so in some. We are aware of only one instance of free and informed consent to the use of a cattle prod on a person. It was for the purpose of learning what the experience felt like. It was not administered with disinterest or malice, but curiosity regarding its effect. The recipient of the shock told me that it was very painful and he would not willingly permit the recurrence.

We think that responsible, caring adults would not permit such harming of themselves or any other human being. We think that no qualified substitute decider could consent to any treatment that he or she would not consent to for themselves and on their own behalf if they were in similar circumstances.

How, then, does abuse happen? It happens when we ignore it; when someone else does it, not us; when we believe that it only happens elsewhere and deny that it happens here. It happens when care givers are socialized into routinely using inhumane methods, when violence against the least audible, least powerful, among us is tolerated, and especially when we give abuse legislative sanction.

If the standing committee abrogates its responsibility to make choices about the way human beings in Ontario are cared for, then those choices will be made by others who may not share your values or our values. When there exists the possibility that the legal power of the state may be



abused to permit the suspension of the rights and privileges of individual human beings, legislators must exercise extreme caution.

We recommend that you delete permission to inflict unjustifiable pain or to harm vulnerable persons and pass the package with its present provisions for ongoingly correcting it.

We hope we have left you enough time for your questions this time around. Thank you for giving us another crack at it. I'd like personally to thank all of those many, many survivors who contributed to this and contributed to informing me and have given me moral support to come again before you. Thank you.

**The Vice-Chair:** Thank you very much. Comments or questions?

**Mr Owens:** The first time I became aware that cattle prods were still being used in this province was a presentation by David Baker from ARCH, and I can't believe that in 1992, with the literature that exists with respect to aversive therapy, that this kind of treatment is still ongoing.

My concern in terms of the clause you address at this point is that until, hopefully, our government addresses this issue, do you not see it being needed in terms of a preventive so that—

**Ms Benmosche':** What is needed in terms of a preventive?

1430

**Mr Owens:** In terms of not allowing a guardian to consent to this type of treatment until it can be removed from use.

**Ms Benmosche':** I don't think that if you list it within the array of treatments that are permissible to be ordered by a judge, to be given permission by a substitute decision-maker—I don't understand the question exactly. I don't know whether you mean that there should be a ban on it pending its listing as a dangerous weapon that should not be used on human beings; that goes without saying. I don't quite understand what it is that you are asking.

**Mr Owens:** I guess my question is that in terms of the clause that you've addressed in section 56—

**Ms Benmosche':** It says that they may permit such other procedures or treatments or whatever; I don't have the thing right in front of me right now. But it is among the things that may be ordered or added to the substitute decision order. It's in the Substitute Decisions Act.

**Mr Owens:** I'm clearly in agreement with your comments in terms of having this type of aversion therapy taken out of practice—

**Ms Benmosche':** I don't think it should be practised at all.

**Mr Owens:** —in this province, whether it's ECT, whether it's—

**Ms Benmosche':** I would add ECT to that, for sure.

**Mr Owens:** Or whether it's cattle prods. I guess my question is, then, that until that can be legislatively done, is it not better to have the clause—

**Ms Benmosche':** To have it regulated, is what you're saying?

**Mr Owens:** That's right, clause 56(4)(c).

**Ms Benmosche':** I really thought about what could we possibly accept as a regulation of this, and about the only thing I could come up with was taking the handle off so that the person administering the shock would be getting an equal amount of shock; that if it was that loving and important to administer to this person, it must be good enough for the giver as well to receive simultaneously.

**Mr Owens:** While it's certainly not on the subject, Chair, I would like, if possible, that we be provided with the names of institutions that are using this.

**Ms Benmosche':** Have you received no requests from presenters that it be retained?

**Mr Owens:** Not as yet. Not in my sitting on this—

**Ms Benmosche':** I would suggest that anyone who wants it retained is probably using it.

I have no personal experience of its being used on me in any way, malicious or out of curiosity. I've gotten quite a jolt from a fence that I misrigged on a battery once, and I do electrical work and I've been bounced a few times, but I've never, ever been in a situation of incarceration where a cattle prod was used or even threatened to be used on me. So, no, I personally have not; however, I have acquaintances and friends who were in that situation. I must admit that they are developmentally handicapped persons, and that this is a very daily and real experience for many of them.

**Mr Owens:** I want to again express my horror and disgust, Chair, that this type of abuse is going on. If we read any kind of United Nations conventions with respect to the treatment of people they call prisoners, you will not see the use of these kinds of implements on people. I think we should clearly pursue that in another forum.

**The Vice-Chair:** I want to thank you very much for taking the time to appear before us today.

**Ms Benmosche':** Thank you.

#### PSYCHIATRIC PATIENT ADVOCATE OFFICE

**The Vice-Chair:** Next is the Psychiatric Patient Advocate Office. Thank you for appearing before us. As you know, you have a half-hour. The committee would appreciate it if you would divide that and give them some time to ask you questions. Begin when you want, and would you please state your name for the record.

**Mr David Giuffrida:** I'm David Giuffrida, acting provincial coordinator of the Psychiatric Patient Advocate Office. Our program is one of more than 30 member organizations of the Ontario Advocacy Coalition. I had the privilege of speaking to this committee last week as one of three representatives of the coalition.

I believe the submission of the patient advocate office has been circulated to you. I thought the committee might appreciate its brevity. Having participated in the drafting of a 24-page document on behalf of the coalition, I thought there was probably little I need to add in writing to that.



What I wanted to do was to focus attention on some particular provisions in the coalition's brief. On one issue that was in the brief presented by the coalition in January, advocacy for children in care, I am certainly available to discuss any points raised in the coalition brief that I'm not proposing to raise myself with you, if you've had any questions about the brief since you last had an opportunity to read it. I know that presenters between last week and now have touched upon some related issues about perhaps recasting the definition of treatment, for example, and issues about who is going to be the rights adviser and who is going to pay for rights advisers.

I also have some additional copies of the advocacy coalition brief with me for those of you who may wish to refer to the wording of it but might not have brought it with you since we last presented to you.

I'd like first to talk about Bill 74 and about advocacy for children in care. I am no closer to understanding why the Advocacy Act is adults-only legislation than I was when it was introduced. Some of the most vulnerable people are people in institutions, and of those people in institutions, some of the most vulnerable of them have to be children. The proposition seems so self-evident from the most cursory review of the print and electronic media.

I enclosed some articles selected almost at random for your perusal, one being "Girls Abused at Hospital, Report Says." This April 1992 article touches upon a report generated by our program in respect of the London adolescent unit at London Psychiatric Hospital. Conditions there have been significantly improved.

I only draw attention to perhaps a two-year-old issue to point out to you just how bad things can get in a situation where there is abuse in the exercise of authority. This included male staff stripping teenage girls naked. Some of these girls reported having been survivors of childhood sexual abuse. Whether or not there was any sexual content in that transaction on the part of the health care staff—and they of course denied there was—it's more than likely that there was significant sexual content and feelings of violation on the part of the girls.

Who was there to listen to them? The patient advocate office was, because we have advocates in the 10 provincial psychiatric hospitals including two, London Psychiatric Hospital and Whitby Psychiatric Hospital, that have adolescent units.

When the patient advocate office moves under the commission and becomes bound by the Advocacy Act, if it remains adult-only legislation we are going to have to tell the young adults and children in these two units that we'll no longer be able to help them assert their rights. I have no adequate explanation for it and I have no alternatives to offer to them.

I'd like to suggest that Bill 74 be modified to include advocacy for children in care, which is the coalition's submission. This would not be advocacy for every vulnerable child—every child with a disability perhaps living happily at home with family. It would be for the most vulnerable children with disabilities who live in institutional settings and perhaps have no family who visit them regularly.

Alternatively, you could at least add a regulation-making power that would allow you to add by regulation children in certain settings as you see fit and as cabinet sees fit. At least there would be the opportunity to add in regulation the two units we now serve so at least children who now receive advocacy services aren't denied them.

I'd like to touch upon non-instructed advocacy in Bill 74. We were pleased to see the significant amendments to Bill 74 since it was introduced to increase the services provided to the most vulnerable people who are unable to instruct an advocate. I was able to hear the submission on behalf of the Alzheimer society where they noted the very large numbers of Ontarians who have Alzheimer's disease and are predicted to have it in the future and the large number of those people who may then end up in our nursing homes.

1440

I think it's probably likely that only a small minority of them in those institutional settings will at some point become at risk of serious bodily harm. I think many people with Alzheimer's at the end stage of Alzheimer's will not be able to instruct an advocate. It's part of the course of the illness. Very few of them will reach the threshold that currently exists in the Advocacy Act to benefit from the service of an advocate: that of harm to the person.

I would predict that probably quite a significant number of them will suffer from poor-quality care. That might include being tied in a chair much longer than their clinical needs require or their security needs require. They'll be tied in the chair for hours and hours because the institution is short-staffed and doesn't have someone to walk around with them and make sure they don't fall. They'll be fed too hurriedly with a purée diet shoved into their mouths too quickly by an overworked staff person who has to feed five people in a short period of time. They'll sit in urine-soaked clothes if they're incontinent and there's inadequate staff to meet those needs, and on and on and on.

There are many quality-of-care issues that an advocate can detect and be effective in helping remedy, but not if the legislation obliges us to turn a blind eye to those important issues but those issues that fall short of being life-threatening.

I'd like to speak about access to information. There are a couple of categories of documents that, as Bill 74 is currently worded, would not be available to advocates. These are documents that the advocates employed by the Psychiatric Patient Advocate Office have had access to since our program began in 1983 and that we find vital to the discharge of our obligations. They include hospital policy manuals. These manuals deal with what authority the hospital asserts to search people upon admission to the hospital, what authority it searches to restrain and confine people, to allow them to have access to visitors, to the telephone—any of a number of issues dealing with quality of care and dealing with the rights and liberties that a person enjoys in an institutional setting.

It's very difficult to advocate effectively for individual clients if you don't know what policy is being applied to those clients that is being used to restrict their liberties. It's almost impossible to do systemic advocacy to change a



system when you don't have access to the documents that document the decisions the system is making now.

As recently as the last week or two I have become aware of a patients' rights organization that tried to get access to the policy in one hospital on stripping patients. Having regard to the article that's included with my materials, you can see why it would be interesting to them to know in what circumstances the hospital thinks it can strip a person's clothes off. They were told, "You can't see that." The provincial psychiatric hospitals are government-run hospitals, and under the Freedom of Information and Protection of Privacy Act they're accessible institutions. In fact, I know a private lawyer who has pried these policy manuals out of the provincial psychiatric hospitals using the freedom of information act.

The public hospitals are not under the freedom of information act; nursing homes are not under it. If they decide that they don't want members of the public to see their policy manuals, the public advocates, consumers themselves, won't see them. It's important to make the statement that these are accessible. That also includes ward motion reports. They might report someone who's been in seclusion since Friday afternoon. The advocate reads the report on Monday morning and decides that this is a person who might want to talk to an advocate and can't dial a phone right now because he's in four-point restraints. These are important documents.

Subsection 27(2) of Bill 74 would deny an advocate access to any information in a record that fits the definition of personal information in the freedom of information act. That's superficially, I guess, a sympathetic provision because we all want to be protective of other people's privacy. But it's flawed and should be removed.

The definition of "personal information" in the freedom of information act can be too broad for these situations. If there is an allegation in a clinical record that the patient's father sexually abused her, that might be relevant to an advocacy issue. The patient may want to see that record, may want the advocate to see that record, may want him to act on that information. Is that the personal information about the father that the patient shouldn't be able to see? Is it personal information that the advocate shouldn't be able to see? I think we'd all agree that there's a vital interest in being able to see that information.

I'm aware of a situation in which the patient alleged that he was physically assaulted by a staff member. Apparently another staff member witnessed it, was horrified by what he saw and documented it in the chart. Is that document in the chart about this incident the personal information about the alleged assailant that the advocate shouldn't be able to see? Any information that's in the patient's clinical record can potentially affect the clinical care of that patient and can affect his or her rights. Any information in that chart will be presented to the Mental Health Review Board or the Consent and Capacity Review Board. They'll look through it and they'll be influenced by what's in there in making decisions about whether the patient is competent or not, whether he or she should be able to leave the institution or not. Our view is that if it's in the patient's clinical record the patient should be able to see it and with

his or her instructions the advocate should be able to see it, whether or not it fits the definition of personal information.

I'd like to turn to Bill 109, the Consent to Treatment Act. In the coalition brief we made reference to the amendment which would permit people added as rights advisers in regulation, and we acknowledge that, given the importance of having a fast response time and being able to respond province-wide, there could be a need to deputize someone, for example, in a community legal clinic who can get to an outlying area, can get to an institution to provide rights advice on short notice. However, it's chilling to think that a person who is employed by a nursing home might be given the conflicting assignment to also give unbiased rights advice to a resident of that nursing home.

I noted that some people making submissions from the perspective of facility operators and providers have expressed their own concern about this section because they worry that they're going to be obliged to do this and will have to foot the bill for these services. The amendment proposed by the coalition would allay their fears and ours. It would say that the person prescribed to be a rights adviser has to be someone who does not provide and is not employed by an organization which provides housing, vocational or health care services to vulnerable people. So we can satisfy the concerns of many different groups by putting in this amendment.

Finally, I'd like to speak about the coalition's suggested modification of the definition of treatment. I think this is an issue that's been hit on as well by provider groups as causing some concern. We are sympathetic to the concern that the Consent to Treatment Act and the due process that it provides be appropriate to the degree of invasiveness of the proposed treatment. No one wants to swat a fly with a cannon, for example. We don't see a need for the Consent to Treatment Act even to apply to such non-invasive interventions as changing a bandage or rotating someone in bed or doing health education for health care consumers.

The only intervention that we can envision that we'd like the Consent to Treatment Act to apply to and is not a controlled act as defined in the Regulated Health Professions Act is behaviour modification. You've just had an articulate expression of some of the abuses of behaviour modification programs, so I hope you will understand why we think that should be subjected to the due process that the Consent to Treatment Act provides.

At the boldface on page 4 we say that we recommend that section 10 be amended to require that rights advice be given whenever a health care provider determines a person aged 12 or over to be incompetent with respect to a treatment, and that's treatment as modified to be controlled acts or behaviour modification, to be administered within a health facility.

I heard some questions asked of other presenters about what the significance is of distinguishing between treatment administered within a health facility and treatment administered within other settings. First, once the regulations establish what is a health care facility and what isn't—we don't know now because it's going to be put in



regulation—that will be readily understood. I think it will be easy to distinguish between a corner doctor's office and a public hospital, for example. So I have no doubt that health care providers will understand what is considered an institution and what isn't.

I think it is a meaningful distinction, because people who are in institutional settings are at greater risk of loss of autonomy. Their ability to make decisions is compromised in those situations. There is an inherent coercion in institutional settings, even in the most benign ones with the most well-meaning health care providers. You're told when to rise, when to sleep, what to wear, what to eat, with whom to associate. It's a very controlling environment and it's a difficult environment for people, particularly people who are not accustomed to being assertive, to assert themselves and say: "Excuse me, Doctor. I know you want to give me that treatment right now, but I'd really like you to hold off until I see a rights adviser." It's our position that people in institutional settings should not be required to be that assertive. If it is a controlled act to be administered in an institutional setting, they should automatically have a visit from a rights adviser.

1450

The distinction between institutional and community settings does have some precedent, I would say. In the Mental Health Act, if a person is admitted as an inpatient, part III says that the attending physician "shall" assess him or her for financial competence. However, if they're an outpatient it says they "may" assess them for financial competence. There is a distinction made, depending on whether they are an inpatient or an outpatient.

I note in the way the Mental Health Act deals with psychosurgery—the lobotomy is a common example of it and thankfully it has fairly fallen into disuse, but it hasn't yet been banned—the section says—it's now renumbered as subsection 49(4)—that the consent to psychiatric and other related medical treatment of an involuntary patient or a substitute of a patient does not include and shall not be deemed to include psychosurgery.

Why won't they let an involuntary patient consent to psychosurgery? They'll let an involuntary patient consent to ECT, consent to neuroleptics. It's because it's such an invasive treatment and so irreversible and so dramatic that we doubt whether an involuntary patient can truly give a voluntary consent. This is an acknowledgement that a coercive setting and being detained in an institutional setting can really compromise voluntariness.

I'll pause there for questions.

**Mrs Sullivan:** Once again I'm going to disagree with you on your view of the proposed amendments to section 10, which would distinguish between controlled acts on the basis of the location in which they are going to take place. I suggest to you that a pelvic examination, by example, is just as intrusive if it occurs and the consent for it to occur is requested in the physician's office, in a home setting or in a hospital.

I think there are many other controlled acts which are in those categories and I think your suggestions with respect to rights advice on controlled acts is a good one, but

I don't think it should be limited by location of either where the recommendation by the physician has been made or where it's going to be carried out. I think that's ludicrous. It gives a standard of rights to people not based on the medical act that's going to occur but on the basis of where either the advice came from or where the treatment will take place.

I am interested in your proposals. I believe the medical association and the college are both looking at the proposals for bringing section 10 together so that the controlled act becomes the determination for consent and for the springing of rights advice. I think that's a very useful suggestion and we certainly made note of it when it was part of the coalition's presentation.

Apart from that, I wanted to ask you: What do you think will happen to your office after these bills are put into place? We now have a situation where there are rights advisers dealing with consent to treatment rather than advocates. We assume the role is different. Will the role of your office now become the rights of the rights adviser or will it continue to be the more extensive role of advocate that you now play?

**Mr Giuffrida:** I'd like to touch upon both of your comments. I'll start with the second one. Our clients now are entitled to the services of an advocate who has access to their clinical records with their consent and can mediate and negotiate their concerns and make referrals. If our clients' legal status is changed, under the Mental Health Act they have access to a rights adviser who visits them to tell them their rights and assist them to apply to the review board if they so choose.

In any reorganization of these services we believe our clients should continue to have access to both. As these bills have been proposed to be amended by the government, the distinction between advocate and rights adviser has been introduced. During this round of amendments, the role of rights adviser is now introduced. That creates the potential to recognize the distinction that has existed in our program for some years between the more narrow function of a rights adviser—very important, but a narrow, circumscribed one—to visit a person without invitation, upon receiving a notice, and explain about the actual or proposed change in his or her legal status, and the full-service role of an advocate. I am fully confident that the commission will understand the need for inpatients in the provincial psychiatric hospitals to continue to have the services of both. It remains to be seen what structural changes will occur when our program moves under the commission.

To turn to your comments about the distinction between inpatient and outpatient settings, I know the coalition has tried to respond to these bills in a spirit of compromise and tried to be realistic about limited resources. It might make it problematic to provide a rights adviser, for example, when a developmentally handicapped young man presents at a dentist's office with his mother and needs a filling. He wants it and she wants to consent to it and the dentist wants to give it. With the previous draft, since that's a controlled act, "No, you'll have to come back in six weeks after you see a rights



adviser." That didn't appeal to many people, so we thought, "Okay, in that situation, how about you just give the person the notice?"

However, once we say that for that kind of controlled act we're content to give the person the notice and tell him of his right to have a rights adviser, that doesn't mean that for every controlled act in every setting we think that just a written notice is enough. For more invasive treatments, for psychiatric treatment in psychiatric settings, we think there should be an automatic rights adviser visit.

So where do you cut it? We said, "We've got to cut it between institutional settings and non-institutional settings." If that distinction isn't going to be made, I'd suggest that everybody gets an automatic rights adviser visit because I wouldn't want to see someone scheduled for an amputation in a public hospital not get an automatic one. So either we make a distinction or we give it for everybody.

**Mrs Sullivan:** I've used the example of the pelvic examination. I suggest to you that perhaps with a consultative process in the course of drafting the regulations, determinations could be made that the finger that requires stitching as a result of a cut on a pop bottle is not going to require the triggering of rights advice for an incapable person, whereas the pelvic examination certainly should.

**Mr Giuffrida:** I'm sympathetic to the distinction you're trying to make, but if I understand you correctly, you're making a distinction within the various categories of controlled acts.

**Mrs Sullivan:** I think that's the way the act is going, and I think your recommendations take it further that way.

**Mr Giuffrida:** We still deal with controlled acts as a single category. You're proposing a refinement that would even put controlled acts on a continuum and say some controlled acts are still fairly non-invasive, like a filling or a stitch, and some are more invasive, like a pelvic exam or an amputation. Of course, that's true. Every distinction you introduce adds levels of complexity and adds greater difficulty in interpreting and applying it, so we'd be asking practitioners to not only know what's a controlled act and what's not, but to know where on the continuum this controlled act is. So there's a cost to be paid for introducing those kinds of subtleties.

**Mr Jim Wilson:** David, I just wondered if you could clarify for me once again—you and Mrs Sullivan were chatting about it—the difference between a rights adviser and the advocate as you have seen it.

**Mr Giuffrida:** The contact between the rights adviser and the client is not typically initiated by the client, for example. Under the Mental Health Act, if a client's legal status has changed in some way, he is either placed on a certificate of involuntary admission or is determined to be incompetent in one or more ways: finances, treatment, access to his files. The doctor completes that determination and is meant to give a written notice to the patient but also a notice that reaches the rights adviser, who then visits that person to explain to them the implications of what the doctor has done and what options are open to them.

They don't wait to be asked by the patient; they proactively go out to visit the patient. If the patient says, "Thank

you for telling me this information. I also have a concern that I don't like a certain drug" or "I don't like my roommate. Could you help advocate for me to the nursing station about that issue?" the rights adviser will say, "That's beyond the scope of my job, but I can make a referral to the patient advocate for that purpose."

**Mr Jim Wilson:** And that model is carried right through the new acts? The distinction is clear in your mind?

**Mr Giuffrida:** The minimal vocabulary is there: "rights adviser" and "advocate." It's not elaborated in the way I've just described to you.

**Mr Jim Wilson:** I guess that's why it's a bit confusing for me. In round 2, after the amendments, we now have rights advisers in Bill 109. My first reading of the amendments was that we were really playing semantics here, that the government can now say, "We're not hiring 250 advocates; we're hiring 100 rights advisers and 150 advocates." Do you really think a layperson's going to know the difference?

**Mr Giuffrida:** I support the introduction of the term "rights adviser" because it gives the commission the latitude to define two different categories and could have two different degrees of training, because the rights adviser function is a narrower one; frankly, two different salary levels as well, which has important economic implications in tight times. I think giving them the opportunity in the implementation to flesh out that distinction is important.

1500

**Mr Jim Wilson:** But do you not get doubling up of duties with the same patient, for instance? When the patient does express, as in your own example, a need for some advocacy and the rights advisers step back and say, "No, I'll have to call in so and so."

**Mr Giuffrida:** In those cases it does, but it is only some fraction of patients who receive rights advice who ask their rights adviser to make a referral to the advocate.

**Mr Jim Wilson:** That's if they know it. Say you don't really know the system and you're chatting with someone—I would assume it's my advocate or someone I'm supposed to tell my wishes to. How many people are actually going to sit down and say, "This is my rights adviser and I can only go this far with this person, and then I might need someone else after that."

**Mr Giuffrida:** I agree with you that some of our clients are not equally clear about the distinction between advocate and rights adviser.

**Mr Jim Wilson:** Some MPPs aren't either.

**Mr Giuffrida:** But in neither case does it impair the delivery of our services. If they don't understand, the advocate or rights adviser can help them understand.

I think to have an advocate who is employed and trained and has an appropriate salary to do full-service advocacy, to do systemic advocacy, to negotiate with the administrator and the front-line nursing staff, to have that person doing the narrow rights advice function might be devoting more resources to that narrow job than it requires,



and it would be more efficient to have someone possibly doing just rights advice.

**The Chair:** Mr Wessenger—Mr Winninger.

**Mr Winninger:** I can understand your confusion, Mr Chair.

A couple of points I wanted to make have already been covered by Ms Sullivan, but there are a couple of points I wanted to raise with you here today, and one is access to clinical records.

There is an exclusion built into the disclosure provision of the Mental Health Act, as I recall, where there's a potential for harm to the patient or to other members of the public. I always had some problems with that exclusion. However, I can see some value in retaining some restrictions on blanket disclosure of clinical information, simply because there may be names of informants in those clinical records whose lives could be prejudiced. It may be that the information they gave was totally fallacious, but their lives may be prejudiced if that information is disclosed to a patient. Maybe I'll give you a chance to respond to that, and then I have one other.

**Mr Giuffrida:** If their information is fallacious, I hope they are prejudiced. I'm aware of a case that came to the attention of our office recently, where one spouse allegedly gave just gross misinformation to health care providers for the purpose of getting the other spouse locked up in hospital and later acknowledged, "Gee, I was under a lot of pressure because of the separation." I'd like that person to experience a lot of prejudice.

Sometimes informants are mistaken. Almost always, when a client has access to a record and looks at what has been recorded about some controversial interaction, some dispute, they have a different take on it than the other witnesses have.

**Mr Winninger:** Let's say the information was accurate, it wasn't fallacious, but names were given of informants whose lives could be threatened by full disclosure. How do you deal with that?

**Mr Giuffrida:** The point I come back to is that this information is used to make serious decisions affecting the life of the patient. The Mental Health Act is one of the few statutes we have outside of the Criminal Code and the Provincial Offences Act that allows people to be locked up, and it allows people to be locked up who have committed no crime and allows them to be locked up based on information given by third parties. We haven't reached the point where we allow our complainants to testify with hoods in our criminal courts; you have a right to face your accusers. In any system that's going to take away your liberty, you should have the right to know who is making what allegations about you.

**Mr Winninger:** I don't disagree with you. I was just looking for reassurance from you.

The other point involved the role of the rights adviser, and I wish Mr Wilson were still here for this discussion. There are situations, such as in the public hospitals, where lawyers are called in to give rights advice, and it would be entirely appropriate for a lawyer to come in and say: "You have the right to a hearing, you have the right to a lawyer,

you have the right to apply for legal aid," this kind of basic information that a patient needs.

Now, the patient may say, "I've heard what you've got to say, but I don't want a lawyer, I don't want a hearing, I don't want to apply for legal aid." The patient may say: "I don't want to see you at all. I don't even know who sent you here, so why should I see you?" But you need that kind of initial intervention to at least assure yourself that the patient knows his or her rights and could act on them if necessary, but you don't need full-blown advocacy.

So what I'm suggesting is that there is an ongoing role for the rights adviser and there is an ongoing role for the advocate, but the two don't necessarily have to be confused in all cases or overlap or be duplicated.

**Mr Giuffrida:** We think the distinction has worked out very effectively in our program.

**The Chair:** Ms Sullivan for clarification?

**Mrs Sullivan:** Yes, Mr Chairman. I'm going to ask that the clerk follow up with the legal counsel to the Minister of Health with respect to Bill 109, subsections 10(2) and (3). In reading this and in discussions with ministry officials, particularly subsection 10(3):

"If, in a place other than a psychiatric facility or prescribed health facility, a health practitioner finds that a person who is twelve years of age or more is incapable with respect to a treatment that is a controlled act within the meaning of subsection 27(2) of the Regulated Health Professions Act, 1991, other than a prescribed controlled act, the health practitioner shall ensure" etc, etc, etc.

This section contemplates a hierarchy of controlled acts, and we would like confirmation of how that hierarchy is going to be developed and, because the word "prescribed" health facility is included, what in fact that means. There's clearly a different interpretation of that section of the act from this presenter than has been the understanding from other presenters today.

I've raised this issue on several occasions. Believing that, the presenters before us understood that it meant a hierarchy of controlled acts. I think the Ministry of Health has been perhaps less than forthcoming with the committee and the people with whom it's been in consultation if that is not the understanding, and I think we all deserve a full clarification.

The other part of that clarification has to be, is a prescribed health facility, by example, an acute care hospital? Is it a dentist's office? Is it a psychiatric institution? What else is going to be left out or put in, quite arbitrarily and without public consultation? We should have had that information in an open way long before this.

**Mr Giuffrida:** If I could just respond briefly, you're certainly correct that that subsection contemplates certain acts, some subset of controlled acts that are prescribed controlled acts, being carved out on it. It's still not a full continuum.

**Mrs Sullivan:** That's right. Who knows? We don't know that.

**Mr Giuffrida:** It seems to contemplate that either it's a controlled act or it's prescribed out of that category, kind



of a two-point scale, two categories, perhaps not a continuum.

**The Chair:** Thank you, Mr Giuffrida. On behalf of this committee I'd like to thank you for taking the time out this afternoon and giving us your presentation. Thank you.

**Mr Giuffrida:** Thank you.

#### ONTARIO DENTAL ASSOCIATION

**The Chair:** I'd like to call forward our next presenters, from the Ontario Dental Association. Good afternoon. Just a reminder that you'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you would keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Dr Peter Fendrich:** I'm Peter Fendrich, president of the Ontario Dental Association. With me today is our director of government relations, Frank Bevilacqua. Let me say that we're pleased to have this opportunity to speak to the committee on Bill 109, the Consent to Treatment Act.

Like many other organizations, we outlined our serious concern with the original package of bills on consent to treatment during the committee hearings in March of this year. We're pleased to see that so many of the revisions in the current bills attempt to overcome the problems that had been highlighted during those hearings.

1510

As health care practitioners, dentists support the idea of informed consent. In very simple terms, we know that practitioners have a responsibility to share information about diagnoses, treatment options, risks and outcomes with their patients. As you know, this information-sharing process is a two-way exchange. The patient must consider all available information when deciding to accept or refuse health services.

We recognize that this process presumes a certain level of patient competence. As we understand the background of the bills, the Consent to Treatment Act is intended to protect those patients who are not capable of making these judgements.

I must say that we are concerned that there is an underlying presumption that dentists and other practitioners would not be able to act appropriately without this legislation. In fact, we're here today to ensure that the mechanisms outlined in Bill 109, the Consent to Treatment Act, do not become so complicated that they leave the vulnerable patient at even greater risk.

In our view, this is exactly what is wrong with this bill. The process has become so complex that patients may not receive the treatment they require in a timely fashion. In fact, the process is so difficult to understand that it may not be applied evenly by practitioners across the province, yet the bill is supposed to ensure that the vulnerable members of our society are treated in a like manner by all regulated health professionals.

One of our concerns relates to the protection of the practitioner who relies on and follows the process outlined in Bill 109. We expect that the amendments were intended

to simplify the process so that only the practitioner prescribing or proposing the treatment will be responsible for initiating the consent process where a rights adviser will be involved.

We know that practitioners will welcome anything that would make the process less cumbersome. However, we're worried about the liabilities that might accrue to the treating practitioner who relies on the prescribing practitioner to complete the entire consent process. At the same time, there is some question about what aspects of the consent process the prescribing practitioner will be held accountable for.

First, we need to be absolutely clear about who the prescribing or proposing practitioner is for the purpose of this legislation. For instance, if I recommend periodontal care for a patient and refer that patient to a periodontist, would I be considered the prescribing practitioner? I certainly don't feel comfortable in taking responsibility for explaining all of the risks and benefits associated with a specific treatment plan that will be detailed by the periodontist.

Again, I think this is primarily a point of clarification. We just need to understand exactly what is meant by the term "a health practitioner proposes a treatment." Is the referring practitioner always the proposer?

We certainly do not wish to see the consent and treatment process become more complicated; however, we need to understand the potential ramifications for any one practitioner linked with providing treatment for a vulnerable patient.

We would like to take some time to explore what sort of treatment services will be covered by this legislation.

The first issue relates to when you have to contact the rights adviser. This question is central to the implementation of the Consent to Treatment Act. As a family dentist, I'm going to have to follow these rules on a daily basis, yet I simply do not understand the rules.

For instance, what are the prescribed controlled acts? In section 10, the bill indicates that a rights adviser must be notified where "the treatment is a controlled act within the meaning of subsection 27(2) of the Regulated Health Professions Act, 1991, other than a prescribed controlled act, and the person objects to the treatment or requests a meeting with a rights adviser."

Under the RHPA, some 13 acts were set out as controlled services. As we understand it, these procedures were controlled because of the potential risk of harm to the patient. If any of these potential harmful services are to be exempt from some aspects of the bill, we recommend that you re-evaluate the need to call in a rights adviser for any services.

I will just continue on this point of contacting a rights adviser. As I understand it, I will have to notify the rights adviser where the patient objects to the treatment. We would like to be very clear on what constitutes objection. The patient's objection is very clear where the patient says, "I do not want this treatment." On the other hand, are we to assume that an uncooperative patient is voicing his or her objection to treatment?

Is the adolescent who has a fear of needles also objecting to treatment? Are we going to place the 12-year-old,



who does not understand either the benefits of the treatment or the risks of not having care, in control of the entire treatment process? As we reported to the committee previously, the ODA continues to support the parents' participation in the decision-making process wherever possible.

I'm sure you will understand that we do not want to sound unreasonable when we ask for clarification on what constitutes objection. As we read this bill, consent to treatment may be expressed or implied. If we're to follow the legislation, the rules must be very clear for everyone. Practitioners must understand what will constitute objection under this legislation.

As we stated in our opening comments, our primary concern is protection for the incapable patient. It is absolutely essential that vulnerable patients do not face treatment delays simply because they are confused about the need for care.

We're pleased that Bill 109 does not envision the need to contact a rights adviser where the incapable person agrees with the treatment plan. We wonder why the practitioner's judgement is questioned only in instances where the incapable patient objects to care. We feel very strongly that vulnerable patients are going to suffer unreasonable treatment delays because of this legislation.

Under the terms of this bill, I will not be able to provide care for a vulnerable patient who has objected to the treatment plan until: the rights adviser notifies me that they have provided an explanation to the patient and the patient does not wish to make an application to the board; or the rights adviser notifies me that the patient refused to meet with the adviser; or seven days have passed since I notified the adviser and no application has been made to the board; or the board gives a decision in the matter and the appeal period lapses without an appeal being commenced or an appeal of the board's decision is disposed of.

I'm a practising dentist. How are my colleagues and I going to track this process? I'm very much afraid that our vulnerable patients who have been sent home to wait to hear from the rights adviser will fall between the cracks. Further, it is not clear to me what happens when the incapable patient refuses to meet with the rights adviser.

We know that this patient has already objected to treatment. Am I to deny needed care simply because the patient is incapable of making a decision, or am I able to contact a substitute decision-maker once I'm notified of the refusal to meet with the rights adviser?

Under the revised bill, the rights adviser is only required to meet promptly with the person who has been found incapable. While we are pleased that practitioners will not have to coordinate private meetings between the patient and the adviser in our offices, the opportunity for continuing patient care in a timely manner is sure to be lost.

Where an appropriate substitute decision-maker is available and willing to make decisions on behalf of the vulnerable patient, we believe that treatment decisions should be made and care should not be delayed.

We would point out that section 23.1 envisions certain instances where the health practitioner would be expected to override the decision of a substitute decision-maker. It is

impossible for health professionals to judge whether or not the person refusing consent to treatment on the patient's behalf complied with the principles of the process outlined in section 14. However, we believe that we should be encouraged to rely on the available substitute decision-maker without calling in a rights adviser.

We recognize that section 24 would relieve the practitioner of any liability for failure to treat when the incapable patient has refused care and the consent process has been followed. Quite frankly, we would prefer to see a more proactive and positive process that would ensure the provision of timely care to our vulnerable patients.

Finally, we would like to ask another question about the age of consent. Will it be necessary to receive permission from the 12- or 13-year-old to share their health information with their parents? We certainly do not envision that adolescents would usually refuse this sharing of information, but it is a point of concern that we would like clarified.

1520

At the same time, we would just note that parents normally would authorize payment for services provided for their children and the billing process would identify the services performed. Again, we don't see these as a major problem, but we would like to hear your thoughts on this.

In summary, we are pleased to see that there has been some progress in Bill 109, but we do continue to worry about the complexities of the Consent to Treatment Act.

We are also extremely concerned about the parts of the process which are not included in the bill. For example, how do we contact the rights adviser? Will our practitioners and patients in northern or remote communities have timely access to an adviser?

Confusion about the process will lead to uneven application of the legislation. In our view, the inability to have the patient meet with the rights adviser in a timely manner may add inappropriate hurdles to needed care for the very patients we are attempting to protect.

Ontario dentists wish to ensure that this legislation will work in favour of our vulnerable patients. We want to ensure that resources are not misplaced in developing unnecessary and complicated administrative procedures. Our limited health resources should go towards patient care.

Let me assure you that the ODA is committed to working with you to achieve this goal.

Once again I would like to thank you for the opportunity to speak to Bill 109. We would be pleased to explore some of the issues we have raised with the members of the committee.

**The Chair:** Questions or comments?

**Mr Alvin Curling (Scarborough North):** I am actually forced to comment on this because all this morning I was at the dentist with about eight needles stuck in my throat and all over. I'm frozen. I just became unfrozen now. That's why I'm able to speak.

**Mr Owens:** That's a miracle.

**Mr Cordiano:** That doesn't apply to his brain.

**Mr Owens:** Are there neurological implications?



**Mr Curling:** So you can see one side of my mouth moving and the other—

**Mr Owens:** Typical politician.

**Mr Cordiano:** Speaking from both sides of his mouth.

**Mr Curling:** It's not the fact that I'm holding back the frozen part.

I think the presentation was well done and many of the concerns you have raised here have been raised by many people who have made their presentations here. If a 12- or 13-year-old was watching the dentist as he tried to do the cleaning of my teeth, I'm sure if he or she were next, he or she would have said no. But if I were able to really explain to the young person that having those teeth cleaned is important to one's health, he would have a difficult time deciding whether he should take the needle to have them cleaned, not knowing the consequences later on.

I am speaking in respect to the age group in which they can make a decision, a 12- or 14-year-old, and your concern whether the neglect of treatment could cause severe problems later on, so people have come forward here and raised that concern. I hope the government is listening, because it's important.

I have also, over the years, admired the dentists especially who have brought in the family to make decisions and make it a family process in having teeth cleaned and being looked after properly.

I'm just speaking from the point of view that I worry a bit whether this will distract and discourage family participation if a young individual of 14 or so would say no because, "I just saw dad going through this and I have to get someone to make this decision for me," after the negotiations went on for months to get that child to the dentist.

It may sound rather light-hearted, but I am as concerned as you are on this. I think most of the dentists should be aware of what is happening here, that you make it known to the government. Those are my comments.

**Mrs Sullivan:** I'm interested in the remarks you've made to the committee with respect to the health practitioner and defining the health practitioner who proposes the treatment as being required to obtain the consent. I think that's an issue that moves into several areas of health practice, and in the dental area it may include not only a patient whom you have referred to another practitioner but a practitioner working under your orders in your office, say, doing the cleaning of teeth or whatever.

But in a physician's office the question of, say, the nurse performing duties under the direction of a doctor also fits into that exact same category. Is the nurse also required to obtain consents as the process moves on and are the activities of the nurse or another practitioner equivalently part of the original course of treatment or do they become a new course of treatment? I think that's something there is reason to clarify, not only in the regs but in the legislation itself.

I also note that you've raised the very issue I raised in the last intervention about the hierarchy of controlled acts; your conclusion is that if there is going to be a hierarchy, in fact you don't need any rights advice at all. That's an

interesting proposal and I think one we'll want to explore further with the Ministry of Health when they come back.

Do you deal much with patients who are in your offices under the aegis and protection of the children's aid society, and are you aware of the concerns they have raised with respect to these bills and about their ability to provide consent if a youth under their care refuses treatment?

**Dr Fendrich:** Two questions. In answer to your question about whether we treat children who are under the care of the children's aid society, yes, and I would think that also our specialists in paediatric dentistry do as well. In terms of my awareness of the concerns they have raised on that issue, I'm not clear as to the issues they have raised.

**Mrs Sullivan:** Their position is that Bill 109 interferes with their responsibilities under the Child and Family Services Act in providing consent and making the treatment decisions they are required to make for children in their care because the parents of the child have not been carrying out those duties as parents.

One of the issues the Children's Aid Society of Metropolitan Toronto and the Ontario society brought to the attention of the committee was the area of dental care where, if nutrition isn't being appropriated provided by the family, it frequently shows in the mouth with additional caries and loose teeth and so on. The requirement of providing consent and ensuring that the treatment is delivered, the children's aid society believes, is an important part of its mandate. I wondered if you wanted to comment on that aspect.

**Dr Fendrich:** The concern we would clearly have is that the creation of those kinds of delays—when you see a patient who is dentally compromised in that manner, to then subject the patient to a significant further delay I think would make their dental treatment that much more complex. In many instances, when you see a patient and you can do some conservative treatment, by delaying that conservative treatment it then changes to become not so conservative, and I just can't see how that would be in a patient's best interests when that situation arises.

1530

**Mr Jim Wilson:** Thanks to the ODA again today for a very thoughtful presentation.

I want to turn to page 7, because I believe you are sincere when you say that you really just want to understand how dentists fit into Bill 109. Most important, you want to understand really what constitutes an objection; I think it's the crux of your written brief.

Through you, Mr Chairman, perhaps we could try to get some answers here today. Given that we have no Minister of Health or parliamentary assistant of Health, perhaps the policy adviser who's here might give us an opinion under Bill 109 of what does constitute an objection in the dentist's chair.

**Ms Auksi:** I can attempt it. That obviously is something a practitioner must determine. I don't know how one could really determine for a practitioner when a person is refusing. If they're in doubt, if they have suspicions that a person is not consenting, then it seems to me they would



need to inquire further. You can't really proceed with a consent unless you're satisfied that the person consents.

**Mr Jim Wilson:** Inquire of whom, or what, further?

**Ms Auksi:** Of the patient.

**Mr Jim Wilson:** What if the dentist, as you said, has really no conclusion whether there's been consent or not? We've heard all kinds of testimony, both in the last round and this round, about young teenagers objecting and just being obstinate to various types of treatment. What type of process is envisioned here? If the dentist is having a problem, what type of help is the government going to give the professional?

**Ms Auksi:** This is the case of whether a rights adviser should—

**Mr Jim Wilson:** Is there going to be, for people in my riding, a 1-800 line where the professional can phone and get some advice?

**Ms Auksi:** I guess we would welcome suggestions from the practitioners if they feel that they're not able to decide these things as they normally would. It seems to me it would be similar to how you would judge whether a mentally capable person had consented. You have to somehow be confident that you have a consent. If you have someone who you feel is incapable, the kinds of communication they would convey to show that they're not in agreement—I'm sorry. I guess I don't quite understand.

If they're resisting the treatment or if they're pulling away from it, and you've said they're incapable, the whole point of rights information is that they would have a right to challenge the finding of incapacity. That would be their one ability to perhaps not get the treatment: if a review showed them in fact to be capable. Their objection would be something that would then mean they would get further information about being able to dispute the finding of incapacity.

**Mr Jim Wilson:** It gets difficult when you're dealing with expressed and/or implied consent. I think that's where I have difficulty going through some scenarios in my mind. Do the presenters have any comments on that?

**Dr Fendrich:** I'll give you an example, if I may. I'd be interested to know how this might apply to my own situation. I have two young daughters. I dare say that when I take them to the paediatrician to get their checkup, and I know they require periodically to be vaccinated, neither of them is too keen about getting a needle. If they raise an objection to that, how does that play itself out under this proposed legislation? It's clearly in their best interests to have a vaccination done but they're not keen to get a needle. What does the paediatrician do? What do I do as a parent? How does that play itself out? That's a scenario that we see in our dental offices not infrequently as well.

**Ms Auksi:** Bearing in mind of course that under the age of 12, under the amended version of the bill, there would be no rights advice.

**Mr Jim Wilson:** But over the age of 12—

**Ms Auksi:** Twelve and up, yes there would be.

**Mr Jim Wilson:** Automatic rights advice in all cases.

**Ms Auksi:** The minute that someone objects I suppose one can try to allay their concerns. If they stop having the concern—

**Mr Jim Wilson:** What if you're accused of coercion?

**Ms Auksi:** I guess an objection that doesn't abate is a standing objection. I don't mean to be facetious, but there is certainly an element of judgement here.

I'd just like to comment on the expressed versus implied consent. There may be some need for clarification still there in the wording of that in the draft, because it certainly was not intended that implied consent could mean an absence of information, an absence of voluntariness. It is simply to mean that it doesn't have to be in writing or someone doesn't have to verbally actually say, "I consent to procedure X." It still requires that the information have been given, that the practitioner be satisfied that the information has been understood and that the person has in fact applied their mind to it and is consenting voluntarily and so forth. The requirements of a consent have to be in place; it's just that the manner of conveying the consent doesn't have to be in those exact words. There is an element of judgement there.

**Mr Jim Wilson:** I didn't want to be rude in my questioning, but I wanted to do this little exercise to highlight exactly what the dentists and the ODA have said here today, that there does need to be further clarification of this section.

**Mr Owens:** I just wanted to follow up on that issue around implied consent, especially for the—if the witnesses would like to respond.

**Dr Fendrich:** I'm sorry. I was consulting with Mr Bevilacqua while you were speaking. I didn't hear your question.

**Mr Owens:** I see. As to the implied consent section, is there not an implied consent, especially in terms of dental work, that a person makes an appointment for the twice-yearly checkup and that implies that there's going to be some digging, some picking and some fluoridation etc. Does that mean with this section now, if I decide at some point during the treatment that no, I don't want fluoride applied or no, I don't want the digging as opposed to the picking, that the rights advice section is going to kick in and the dentist has to stop treatment?

**Ms Auksi:** In rights advice, of course we're talking about someone who is found mentally incapable, so someone making a dental appointment for himself would be unlikely to be mentally incapable of making a treatment decision. I suppose it's vaguely possible.

**Mr Owens:** On Thursday; maybe on Friday they're not. Who knows?

**Ms Auksi:** In fairness, in terms of someone who is mentally capable, the act of going to a practitioner's office is a part of an acknowledgement that you have a treatment need, you want it attended to; there's information given about what is wrong, what can be done about it. There is an element where you don't have to really spell out your agreement to what is happening as long as you've been given the necessary information. You can withdraw your



consent, of course, because if you decide that something is being done or that something is being proposed that you hadn't envisaged or that you disagree with, you don't have to go through with it to the bitter end because you, somewhere way back when, said yes, you'd like that.

**Mr Owens:** Then in terms of the advice that you would give or the ministry would give to the Ontario Dental Association in where you stop, where do you draw the line and what is reasonably acceptable under implied consent versus what you would ask for explicit consent for?

**Ms Auksi:** I'd really like to make sure that it's understood that implied consent is not something that is being used to deal with the issue of mental incapacity. Someone who's mentally incapable can't imply a consent, because they can't consent. I hope I didn't confuse the issue by drawing that in because it arose at the same time as the issue of implied versus express. When you're talking about an incapable person and a substitute consent made on their behalf, then basically the substitute has to express a consent on that person's behalf or at least by some action to show that they're consenting after they've received the information.

I'm sorry. Perhaps I don't understand your question.

**Mr Owens:** Maybe I don't understand the concerns of the dental association. I guess their concern is that they have somebody who they want to treat and no matter what the treatment is, if the person refuses, competent or not or capable or not, the rights advice process is going to kick in. Is that what I'm hearing?

1540

**Dr Fendrich:** I think I have an appreciation for the question that you're raising. If I can put it in a context, I can think of many instances where a patient presents and the treatment plan and different phases of the treatment plan may spread over multiple appointments. Say the patient presents for the first two appointments and the consent, implied or otherwise, is there. Say a particular treatment plan may spread out over six or seven appointments. Does the whole consent process have to take place each time, or when one explains the initial overall treatment plan is consent agreed upon there?

I think Mr Owens is giving a scenario where patient X has a change of mind or whatever, and does that then require a practitioner to go through a consent process at every patient interaction.

**Ms Auksi:** If you had an incapable patient and there was a course of treatment that was spread out over a period of time, after the finding of incapacity is made initially, after it's established either that they are or aren't going to dispute the finding of incapacity—and say they don't, which would probably be by far the most usual case—then the treatment could proceed on the substitute consent and that would cover the remaining parts of that course of treatment.

It's not the administration of the treatment each time that triggers the need for the process, but rather the consent to that series of interventions that may be seen as a whole. In fact, in some cases—the nursing home people, for example—it is pointed out that they're dealing with a wide

variety of treatments that are going to be ongoing for people with multiple kinds of treatment needs. It doesn't mean they have to deal with them all discretely and go through the process many different times. They can say, "This person is incapable for all the treatments he's going to need." They would get the rights advice the one time dealing with it all, and unless something new and different arises in the course of that person's stay in the facility, then they really would be able to obtain consent for ongoing treatment based on a consent at the time.

In the case of a mentally capable person, of course they are free to withdraw their consent. In the case of an incapable person, the substitute may withdraw the consent; he may decide, "This is not doing the person the good I thought it would."

**Dr Fendrich:** I appreciate your clarification on that. That certainly wasn't apparent or clear to us from reading it.

**Ms Auksi:** We thought we had clarified that in some of the wording around that "a treatment" includes "a course of treatment" or "a plan of treatment." But it is something that bears emphasizing.

**Ms Zanana L. Akande (St Andrew-St Patrick):** I appreciate the presentation especially, and I recognize the importance of it in spite of the levity.

I'm interested, though, in your experience as a dentist. It seems to me that we've formulated a situation here, some of the examples you give, where consent and who is capable of giving it and how it is given seems common. Is a reluctance to endure pain inferred by many dentists as a withdrawing of consent to have treatment?

**Dr Fendrich:** Are you asking the question as to how the legislation would apply to that, or how we deal with that at the present time?

**Ms Akande:** Yes, at present. Very often children, 12-year-olds, 13-year-olds will cringe and shy away and do all kinds of things, even some of the things Mr Curling was referring to. Is a reluctance to endure pain at present inferred as a lack of consent to have treatment?

**Dr Fendrich:** Obviously we can't treat an uncooperative patient. We don't treat patients against their will. A reluctance to experience pain would trigger us to work with the patient to establish a rapport that will allow them to be more receptive to whatever treatment needs they require.

**Ms Akande:** And that is what most commonly happens in those situations.

**Dr Fendrich:** Yes.

**Ms Akande:** Is there anything in this legislation which would allow you to believe that would not be your course of action in the future?

**Dr Fendrich:** Yes.

**Ms Akande:** And that is the way it is written.

**Dr Fendrich:** That's our concern: Does that kind of objection to perceive pain constitute a withdrawal of consent?

**Ms Akande:** Certainly it wasn't the intention when the legislation was written.



**Dr Fendrich:** That's one of the points we would hope can be clarified.

**Ms Akande:** Because I would suggest that you will probably still have many 12-year-olds and even 50-year-olds who are reluctant to endure pain. We would certainly want to clarify it, if such is necessary, so that you didn't see that as a withdrawal of consent.

**The Vice-Chair:** Thank you very much for that presentation.

#### ONTARIO SOCIETY OF PAEDIATRIC DENTISTS

**The Vice-Chair:** Our next witness up is the Ontario Society of Paediatric Dentists. Good afternoon. As you know, you have a half-hour for your presentation. I would appreciate it if you would leave some time during your presentation so the committee members can ask you questions. Before you begin, can you please state your names for the record. Begin any time you feel comfortable.

**Dr Jack Maltz:** Thank you very much. Good afternoon, ladies and gentlemen of the Legislature. Dr Andrews and myself are making this presentation on behalf of the Ontario Society of Paediatric Dentists.

In reading over the revisions to Bill 109, we were impressed by the amount of work done by your committee. You obviously listened to the concerns of the presenting groups and addressed many of our concerns. However, in spite of this, there are still several areas we feel can be improved. The purpose of the bill, as we understand it, is to give patients rights and some form of protection from treatment they do not desire or deem unnecessary.

The bill, however, may do exactly the opposite. Instead of giving patients rights and choices, the bill will actually hinder and delay treatment, leading to undue suffering, more extensive treatment and drive up the cost of dental care.

Because many of these individuals lack communicative skills, they may suffer needlessly in silence. A patient with cerebral palsy or autism may not be eating well as a result of an infected tooth, yet he may not be able to communicate this problem to his or her care giver until the problem becomes acute. Thus, timely treatment is essential in these patients so that dental treatment does not deteriorate.

As paediatric dentists, our areas of expertise are in child management and care for the developmentally delayed. A good portion of care for the disabled is performed by general dentists. However, when and if they run into difficulty, we are the people of last resort, so that we often deal with the most difficult cases.

We basically see patients in three types of settings: (a) private offices, (b) hospitals and (c) institutions. In the private office, some of these patients are extremely functional and have no problems accommodating themselves to a dental environment. Others are a bit more difficult to handle, but the amount of dental work required is minimal. For the more severely disabled patients who require extensive dental work, a hospital setting where the patient can be safely sedated or given a general anaesthesia is advisable. The most seriously disabled patients are institutionalized, and these people may require special care even for minor procedures.

1550

At this time I would like to take a case and run through the procedures as we interpret them and show the problems that we perceive may occur if Bill 109 is not amended.

1. Say a 13-year-old developmentally delayed child shows up with a care giver for dental treatment.

2. If he objects to any controlled act, he can be deemed incapable by the doctor, and the doctor must notify him in writing that he is deemed incapable. The doctor must notify the rights adviser that this person is deemed incapable.

3. The rights adviser meets with the patient promptly.

4a. The doctor might wait seven days after the rights adviser meets the patient to see if the patient makes a board application to contest the doctor's assessment of incapacity. The rights adviser notifies the doctor if there is no application to the board after seven days. At this time, treatment may proceed.

4b. On the other hand, if an application has been made to the board, the board must hold a hearing within seven days and render a decision within one day of the hearing and notify the doctor in writing within two days.

At this time, if everything went smoothly, a delay of 17 days has occurred. If the patient is incapable, the doctor can proceed with treatment, with the guardian's approval, if there is no appeal. If the patient has been deemed capable, no treatment is carried out.

After the board's decision, the patient can appeal the decision in seven days, thus adding seven more days to the delay. Now 24 days have accrued, if everything went according to plan. The delay can obviously be much longer.

A patient with large caries who receives timely treatment can be easily treated with simple dental restorations. If the teeth become abscessed, dental fillings are not adequate. The person may now need multiple root canal therapy, and because these teeth have been weakened, they would have to be restored with caps. Alternately, the infected teeth would have to be extracted and a denture placed, especially if the person has a heart defect. Sixty per cent of Down syndrome patients have such defects.

Many of these people do not adapt well to new dentures, and therefore eating and possibly speaking would be more difficult. If a hospitalization procedure is required for treatment, a rebooking for a general anaesthesia may add anywhere from one to six months to delay of treatment, as there is a severe shortage of these services now available.

In scenario 4b, if the patient is 16 years old the doctor can notify the public guardian and trustee if the guardians do not have proof of power of attorney. The onus is now on the doctor to track the process and find out if notification has been obtained and in which jurisdiction. We are now put in the unacceptable position of enforcement officers.

Some other problems we perceive are in the tracking process. We often receive referrals from a wide geographic jurisdiction, and as many of these referrals could be in midtreatment, we would have to know at which stage they are at in the process and also which jurisdiction has okayed the treatment. Will there be a central registry where



we can get this information? Further, because of the complication, we recommend that all communications thus be in writing.

In making an application to the board, the doctor is a participant. However, Bill 109 does not specify whether he is to appear in person or whether a written report will suffice. And who will remunerate the doctor for the time and effort spent?

In the section on emergency care, we feel the word "pain" should be added to the definition as patients may not be in pain at the time of the actual dental visit, but a toothache is transitory and will recur.

Last, the patients can reapply the entire process in six months, very convenient if the patient comes in for six-month recalls.

We feel the process of the law must not be so onerous as to victimize the people it is trying to help. These areas require some amendments so that treatment is not unduly delayed. We are in accord with the intent of Bill 109 and will gladly be of any assistance to make the bill and the necessary process run as smoothly as possible. Thank you for your time.

**Mrs Sullivan:** You've really pointed out the practical applications of two conflicting rights: One is the right to treatment, and the other is the right to due process in terms of a capacity determination. This issue has been brought before the committee by several groups and organizations and is one we're certainly concerned about, where the best interests versus the rights are in conflict.

I think you were in the room when the ODA was presenting. At that time, I asked them about the impact on the children's aid societies for children in their care. I wonder if you'd like to add to your presentation with respect to those situations now. Would you feel, knowing a child was in a CAS's care, that you would be able to treat that child under the direction of the CAS or would you feel that under this bill you would be constrained in doing so?

**Dr Maltz:** I feel that under this bill we would be constrained in doing so. We would have to find a proper guardian. It would not be clear and I would feel hesitant, unless it would be an emergency situation, in dealing with the situation.

Normally, the way we do things in our office is that when a patient comes in, he or she has a checkup. We do see many children from children's aid and what we do is give them a checkup, work up a treatment plan and send it to the children's aid and ask if there's anybody else who needs to know. But under the bill the way it is drawn up right now, I don't know if we would even be able to do a treatment plan.

**Mrs Sullivan:** That's interesting.

I'm going to ask, as a result of those comments and other comments we've received from children's aid societies, that we ask counsel and the Ministry of Community and Social Services as well to appear before the committee and discuss some of the issues that are of some concern. We have asked for legal advice from the Ministry of Health through a fairly botched vote that was taken here the other day. I think it would be very useful to have

Comsoc with us to discuss this and other issues. We know the CASs have raised, particularly, the question of dental care. I don't know what the schedule is looking like, but I think that the committee has the right and deserves that information from Comsoc.

**The Chair:** Just a reminder, Mrs Sullivan, that tomorrow is the last day.

**Mrs Sullivan:** I understand that. We can make a call anyhow.

**The Chair:** We can try and do that then.

Okay, we do have an opening tomorrow at 2:30, so we'll see what we can do.

**Mrs Sullivan:** Good.

**Mr Jim Wilson:** Thank you very much for your presentation. Mr Sterling and I were sort of kidding here. I think sometimes our presenters must think they are a bit crazy or something when they present us with these scenarios that at first glance don't seem plausible, but when you are familiar with legislation and you go through your scenario—both of the two you presented—I think you're dead on. I think you deserve a response.

I'm going to ask, Mr Chairman, whomever you deem appropriate to give the committee a response, to take the scenarios as outlined—particularly the first one which involves the 13-year-old developmentally delayed child—and perhaps have the ministry get back to the committee and tell us what the response is in terms of some of the concerns raised in this brief specifically. I think it's a very straightforward scenario. As I understand the legislation, I think this group has got the steps down correctly. I think if the public were aware that this is what the legislation calls for at this stage, they would find it totally unacceptable.

Secondly, I want to ask the questioners to help put things into perspective for parliamentarians. What do you do now in terms of dealing with a developmentally handicapped or mentally impaired child? You're the family dentist and you've been dealing with the child for a number of years. What happens when that child turns age 16 and under the law could consent or not consent to treatment? Is there a difference in dealing with the child you've been dealing with for many years? Do you want to explain that?

1600

**Dr Paul Andrews:** Certainly, at the present time, and we see many developmentally delayed children for a very extended period of time, one of the interesting points about paediatric dentistry is that when they become 16 they continue on seeing their paediatric dentist because there just is no where else for them to go.

As Dr Maltz indicated, we see perhaps the most difficult cases to deal with, and just because they, so-called, become adults, doesn't mean they don't require the care and don't require the expertise, and there is no other specialty out there that's available to deal with them.

As such, we continue to provide care for these individuals. Historically, we have always turned to the families for consent as to the procedures we felt were necessary for these patients. Traditionally, we would consult with them for that consent.



Under the proposed Bill 109, under subsection 11(1), for anyone who is 16 years of age who is deemed incapable, and we feel that this incapacity under subsection (2) will extend for beyond a six-month period, we are then mandatorily required to notify the public guardian and trustee.

This to my mind puts me in a very untenable situation. I've been dealing with this family for upwards of 14 to 16 years, every six months, having them consent to treatment. Now this child or this individual becomes 16 years of age, and because they have not obtained legal guardianship over the individual, I have to turn to them and say: "I'm sorry. I can no longer include you in the decision-making process as to the appropriate treatment for your child. I must mandatorily notify the public guardian and trustee's office that your child is incapable, and I must consult with that office as to the appropriate treatment for your child."

As a parent, I would be horrified if a dentist tried to tell me that I was incapable of caring for my own child or to go to the expense of hiring a lawyer and going through the process of obtaining power of attorney over my child, whom I have been caring for since birth.

Under the bill, if, as the dentist, I do not notify the public guardian and trustee of the situation, I am at risk of a \$5,000 fine for each case that walks through the door.

**Mr Jim Wilson:** Yes, it does appear ludicrous. We'll see what we can do for you.

**The Chair:** Thank you, Mr Wilson. I think we can work through that one case now.

**Ms Auksi:** I'd just like to say that in most details it's correct, the case of the 13-year-old. There's one error I think in saying that the doctor must wait seven days after the rights adviser meets the patient to see if the patient makes a board application. It's the responsibility of the rights adviser to meet promptly with the person and then to report back to the doctor. If, however, they don't, which could occur if the meeting never took place, for example, then if after seven days they haven't heard from the rights adviser, there's a presumed okay to go ahead.

If there's no notification that there is a board hearing and there's no information that the person is making an application to the board after seven days, then they could go ahead, but they probably would have heard earlier from the rights adviser in those cases where a meeting does happen.

**Dr Andrews:** The big problem we have here is in the tracking of the procedure. We see the person initially. We inform them that they are incapable and that they have the right to meet with a rights adviser. We notify the rights adviser.

Then under the context of the bill, it says that the rights adviser must meet promptly. We don't know what time period that constitutes. They then meet with the rights adviser. Now there is that seven-day period in which the patient can decide to make an application to the board, and even if immediately after meeting with a rights adviser, they are content with the situation, under the context of the bill, they have that seven-day period with which to make

the application to the board to contest, and so we have to wait that seven days.

**Ms Auksi:** Not necessarily. If there's no indication at the meeting that the person wants to make an application or the person doesn't say, "Well, let me think about it," then the rights adviser would just notify the practitioner.

I guess what I'd like to say then, in addition to that, and not by way of defending the process beyond a certain point, is the fact is that the whole hearing and appeal process is one that is available to people, but it isn't something, from experience with the Mental Health Act, that huge numbers of people actually exercise. It's a kind of safety valve for those situations where people truly have a concern, or where there are borderline calls of incapacity. Someone who is really profoundly incapable is not at all likely to take these steps, someone who is so confused that he couldn't even get his thoughts together to do it.

In a way, that's an indication of their incapacity, but this does help to ensure that in some cases that have been brought to our attention, for example where a difficulty in communicating is the problem rather than mental incapacity, it gives one a way of really checking on the fact that the person does know that he has a right to appeal the finding.

In the Mental Health Act area, the number of cases that actually go to review board hearings in a year—I think I've mentioned this to the committee before—out of about 50,000 admissions to psychiatric facilities—of course there would be many cases of people being incapable to consent—there have been in the course of a usual year about 100 hearings in the entire province.

**Dr Andrews:** The major problem we see with that, especially with regard to the outpatient care of the special needs patients, is that there are a number of centres—one in particular in Mount Sinai Hospital—that on a regular basis, twice a week, see outpatient special needs patients, mentally handicapped patients, for their dental care.

Under those circumstances, every time a patient arrived at the door and objected to having treatment performed, which occurs on a regular basis for something as simple as an examination and cleaning, under the confines of this act we have to stop and initiate the process with which to have, if they're over the age of 16, a public guardian and trustee appointed and to have a meeting with a rights adviser etc. Basically, what it would do, especially to that type of program, is that it would close it. We would be unable to operate.

**Ms Auksi:** Actually, perhaps someone from the Ministry of the Attorney General could speak further to that, but in the case of someone with mental incapacity who is frequently objecting to treatment and is incapable, then a far better approach would be to undertake the guardianship provisions. This could be a parent who could obtain the guardianship, and then that would mean there would be a formal assessment carried out and that would mean not having repeated rights advice because there would be a provision for that.

**Dr Andrews:** I certainly understand that in the long term that would be the preferential situation to have



develop, but we will see 25 patients in the course of an afternoon. At the end of three weeks we will have seen hundreds of patients. If we have to ensure this process for each one of those patients, whom are we treating?

**Mr Jim Wilson:** The fundamental issue here, I think, is why are dentists even included in this legislation under the definition of "health practitioner"? The government often pulls out newspaper stories to justify various aspects of this legislation, that there's abuse going on with vulnerable people, but I've never read of families taking their vulnerable son or daughter to the dentist for torture sessions. I've just not read of it.

I don't know why dentists and dental hygienists are even included in this. Is there perhaps somebody who could tell me the rationale? It seems crazy that you've got to get a guardianship order to take your kid to the dentist. Have we lost our marbles totally? I feel I have after weeks of these hearings. But it's getting crazier and crazier.

Perhaps I could have a serious answer, though, from either the spokesperson for the Attorney General or one of the parliamentary assistants. Have you seriously considered or is this just blanket legislation and, for the fact that they're health care practitioners, they're rolled in with everybody else.

1610

**The Chair:** Mr Winninger, your response.

**Mr Winninger:** Sure, I'd be pleased to respond to that. Aside from situations where there can be a finding that this patient is in need of emergency care, and there will be those situations, there will be more marginal situations where a child appears to be incapable and you'll have to resort to section 16. So let me talk about section 16 of the Consent to Treatment Act for a moment here and go through the hierarchy.

If you look at section 16, the first person the health care practitioner can turn to in the dentist's office is a guardian, if a guardian has been appointed. I put it to you that it's unlikely a child will be seen to be incapable for the first time in the dentist's office, but that's not beyond the realm of possibility. It's quite likely that a guardian will already be involved on behalf of the child.

But let's say there is no appointed guardian and let's say there is no attorney for personal care, because it's a child we're dealing with and he or she can't execute a power of attorney anyway, and let's say there's no representative appointed by the board under section 27 to consent, and let's say the child is quite unlikely to be married.

Once you get past the incapable person's child, the next person the dentist turns to is the incapable person's parent, or if the incapable person is less than 16 years of age, a person lawfully entitled to give or refuse consent to treatment on his or her behalf. Then you go to the brother or sister and then you go to any other relative. It's only at that stage that you start looking at the public guardian and trustee. That's not the first person you have to go to. You don't have to get a guardianship order. You can turn to the child's parents because that's specifically laid out in paragraph 16(1)6.

Maybe you can illuminate for me where your concern resides, because I quite frankly feel, in a close reading of this section, that the parents' rights to consent on behalf of the child are there. It's quite clearly set out.

**Dr Andrews:** Just give me a second to re-read this. That's not how I understood it.

**Mrs Sullivan:** In the meantime, I wonder if I could put another issue on the table that is comparable to a follow-up to Mr Wilson's question, why dentists are in this at all. The issue I raised about the requirement for obtaining consent, if you look at how a health practitioner is defined, you'll see that dentists themselves are defined as health practitioners and therefore are required to provide consent. However, dental hygienists are also health practitioners required to obtain consent.

Dental hygienists work at the direction of the dentist and therefore there would be two processes of consent required. Therefore, the next question becomes, why would the dental hygienist be included in this legislation as well?

**Dr Andrews:** Just to respond to your comment, under section 11 where it is referring to notice to the public guardian and trustee, it states that "a person who is 16 years of age or more is incapable with respect to a treatment and who is of the opinion that the person may need decisions with respect to treatment to be made on his or her behalf on an ongoing basis may notify the public guardian and trustee of the matter, using the prescribed form."

Subsection 11(2) says, "The notice is obligatory if the health practitioner is of the opinion that the incapacity has lasted for at least six months and is likely to continue."

That supersedes any involvement of the parent because I am now obligatorily required to notify the public guardian and trustee, now that he is 16 years of age, that this individual is going to have an ongoing incapacity.

**Mr Winninger:** Maybe at this point I'll defer to Mr Fram so that he can reconcile these two sections for you, unless the Ministry of Health wants to do that.

**The Chair:** Mr Fram.

**Mr Winninger:** Have a seat.

**Mr Steve Fram:** Thanks. Everybody always gets excited when I get on my knees. Women think I'm proposing.

**Mr Jim Wilson:** I was just going to ask you to explain that, Mr Fram.

**Mr Owens:** We'll leave it to your fertile imagination.

**Mr Fram:** You were alluding to section 16?

**Dr Andrews:** No, section 11.

**Mr Fram:** All right. First of all, in our first illustration we weren't talking about a person over the age of 16. Nevertheless, what this is supposed to do is to be a provision that, where a health practitioner finds that somebody is going to be incapable of a broad range of things and is going to need a substitute decision-maker on an ongoing basis, since the public guardian—if you have a family member and the family member can consent, there's



obviously no reason to inform the public guardian and trustee. There is somebody to make a substitute decision.

**Dr Andrews:** That's what I would hope would be the case, but that's not what the bill says. Under subsection 11(2), it says I am obliged to inform the public guardian and trustee, and later in the act, I am then subject to a \$5,000 fine if I do not comply with the provisions of the act.

**Mr Fram:** Okay. You are to read (2) with (1). Subsection (1) starts out with a hypothesis that you have found that a person 16 years of age or more is incapable with respect to treatment and you are of the opinion that the person may need decisions with respect to treatment to be made on his or her behalf on an ongoing basis.

**Dr Andrews:** Right.

**Mr Fram:** Okay. So you have come to the conclusion that not only is this person incapable with respect to the particular treatment decision about his teeth, but this person is going to have an ongoing need for decision-making on an ongoing basis; not a sporadic basis, but an ongoing basis.

**Ms Akande:** Sorry. May I interject and tell you that it says in section 12, "Sections 10 and 11 do not apply if the person has a guardian of the person appointed under"—

**Mrs Sullivan:** That's the point.

**Dr Andrews:** Right. Under section 12, it says that that guardian is under the Substitute Decisions Act, 1992. Under the Substitute Decisions Act, parents are not automatic guardians of their children over the age of 16. An application must be made for a power of attorney for personal care, for that individual to be a guardian of that individual over the age of 16.

**Mr Fram:** Okay. Over the age of 16, if people know who they can trust and that they will need somebody to help them with decisions, they can choose their parents.

**Dr Andrews:** Absolutely. If that process has occurred.

**Mr Fram:** Right. So if that's done, we get the public guardian and trustee out of the issue.

**Dr Andrews:** Then you don't have a problem. I think the issue is—

**Mr Fram:** Okay. Now we get to the second subsection. You now have concluded that the person in the hospital is going to have ongoing decisional needs for a period of more than six months and doesn't have a guardian and doesn't have an attorney, so it says you have to give notice to the public guardian and trustee of the situation.

**Dr Andrews:** Right.

**Mr Fram:** What the public guardian and trustee is going to do is to check out the situation and see if somebody can be appointed as the attorney for this young person.

**Dr Andrews:** My question is: Is this doing a service to the needs of the patient? We are inflicting a process on this individual that can potentially lead to harm. We're presenting them with an extended delay, because they now have to meet with the public guardian and trustee. The

public guardian and trustee has to check into the situation and see if the best thing is to have the parents be the guardian. They are then instituted as the guardian—

**Mr Fram:** There's no delay in the delivery of dental service.

**Dr Andrews:** Why?

**Mr Fram:** Because it doesn't say that you stop. This is just—

**Dr Andrews:** I don't have informed consent then.

**Mr Fram:** No, but you've got the parent to consent. You see, we go into the—

**Dr Andrews:** But they are not the guardian. How can they consent if they are not the guardian?

1620

**Mr Fram:** Because under this act, they are the highest person on the list to consent to the particular treatment that you are giving. What that section that we were talking to is about is to alert the system to the fact that somebody is going to be in the need of a guardian or an attorney on a long-term basis. In the meantime, we plug back into the Consent to Treatment Act and we're saying, "Okay, if you've got the parent to consent and the person is incapable but doesn't want to go to the review board, go ahead."

**Dr Andrews:** My concerns then are twofold: One is that it puts the health practitioner in the position of being an enforcement officer, where I have been dealing with this family for 10 to 12 years without any problems of consent or involvement or anything like that. This child then turns the age of 16 and I now have to inform the public guardian and trustee of the situation.

To me, that puts me in a position where I may not belong. Because this child is 16 and the parents do not have official guardianship over the child, I am in a position where I have to make this notification and I don't feel that I have any responsibility for doing that.

**Mr Fram:** Let's turn this around. You are being both helpful to the child, to the young person, and to the parents.

**Dr Andrews:** The parents will not view me as being helpful.

**Mr Fram:** I know, but you see—

**Dr Andrews:** The parents will be viewing me as putting up another roadblock that they have to jump over.

**Mr Fram:** Yes, but you're perceiving it as a roadblock. Part of this whole process of public education, this person that you've identified is going to have ongoing needs, health and otherwise, over a long period of time.

**Dr Andrews:** My point is that the Ministry of Community and Social Services should be taking the responsibility of making this notification to the public guardian and trustee, and it should not be the position of the paediatric dentist, or any other dentist or health care practitioner, to have to make a notification to the public guardian and trustee of the incapacity of this individual.

**Mr Fram:** But you're not doing anything bad. It's not a bad thing.



**Dr Andrews:** You do not perceive it as a bad thing, but the parent who then has to deal with the process perceives it as meddling on my behalf, and I do not feel that I have any business being put into that position. That's my first concern.

My second source of concern is that it's not always the parents who bring the child, especially the special needs individual; it's not always the parents who brings that individual to the dentist. Now I have to deal with the case worker or attendant who has brought the individual to the dentist. So I don't have that necessary consent that you say I have under this bill through the parents, because they're not the parents and they don't fall within the listing of family or any other relative or the incapable person's brother or sister within that listing. I now have to deal with that individual.

**Mr Winner:** Could I just complete the response very briefly to the question that was posed? Looking at these two sections very carefully, I note that section 11 only applies to a person over 16 years of age, that it will not hold up treatment of children in any way, and I don't see any logical inconsistency between these two sections.

Section 11 merely provides a safeguard for those people over age 16 that may require some plan of care in the future, and it's made mandatory if it's six months. But to an ordinary parent who brings a small child for treatment, the parent will make the substitute decision to consent or refuse treatment on the child's behalf and you don't need the involvement of—

**Dr Andrews:** Absolutely, and I appreciate that. I think that change that has been made to the bill in order to designate age has been a major step forward.

**Mr Winner:** So bringing in the public guardian and trustee here is a bit of a red herring because we're not dealing with the PGT in these circumstances at all.

**Dr Andrews:** Okay, the concern—and I'm not referring to the young child, I am referring to the individual that is 16 years of age or older that I will have to deal with as a paediatric dentist because I am the only person out there that the family has available to them to provide treatment.

**Mr Winner:** Well, would it not concern you where you've got a person over the age of 16, seemingly incapable, that there be some protections there before you treat that person outside of an emergency situation?

**Dr Andrews:** The protections that I have had in comfort is the parent and having the parent who is the primary individual who is responsible for the care of this individual to provide to me the consent that is required, and that would continue under this bill.

My only concern here is that I'm being put in the position of notifying the public guardian and trustee of the situation, and I don't want to feel that it's our position to be put into that place. That should be up to the ministry of social services, not up to the individual dentist to ask each individual: "Do you have power of attorney over your child? You don't? Okay, well then I have to call the public guardian and trustee." That's not my place.

**Mr Winner:** Well, I don't know how often you encounter parents with children over the age of 16, but I

can't believe it's that prevalent that it would pose an insurmountable problem under this legislation.

**Dr Andrews:** At Mount Sinai Hospital, we see 25 patients a day twice a week, of which I would estimate easily a third would fall into that category.

**Mr Winner:** Incapable and over 16?

**Dr Andrews:** Absolutely.

**The Vice-Chair:** I want to thank you very much for that fine presentation.

#### CITIZEN ADVOCACY WINDSOR-ESSEX

**The Vice-Chair:** Next witness is Citizen Advocacy of Windsor-Essex, please. Good afternoon. You have a half-hour for your presentation. The committee would appreciate if you would leave some time at the end of your presentation so they can have some questions and comments. Before you begin, could you please read your names into the record. Begin when you're ready. Thanks very much.

**Ms Shirley Jarcaig:** Hello, my name is Shirley Jarcaig. I am the managing director of Citizen Advocacy Windsor-Essex. I would also like to introduce you to our president, Nola Millin, who is setting next to me, and to Marie LeBel, who will be acting as Nola's interpreter since she communicates through a word board.

We wish to thank the committee on administration of justice for this second opportunity to speak with you about the proposed advocacy legislation. Although we definitely have our concerns about how the new advocacy system may affect our organization and the future of voluntary, long-term advocacy in Ontario, we wish to also express our support of the recent changes made in Bill 74. We also express our support of recent changes made in Bill 74. We consider this bill a good, sincere effort on the part of this government to address the needs of a growing segment of our population who've been ignored and neglected for far too long.

The clarification made in Bill 74 that states that no service-providing community agency can also provide advocacy services will ensure that there will be no question of conflict of interest. It will also ensure that the system will be truly consumer-driven.

Empowerment of the disabled and seniors can only happen when they are guaranteed control. Years of conditioning and prejudice must be eliminated by education and example. The Advocacy Commission and the advocacy system is the example that must be set by this province to prove not only to the disabled and senior communities but the entire society that we truly believe in the equality of all of our citizens under the law. Who is better qualified to safeguard the quality of services than the people receiving them?

We would also like to express our satisfaction with the introduction of an advisory committee to the Advocacy Commission that will recognize the interests, concerns, responsibilities and rights of families and care givers. The perception expressed by many groups that advocates would be a divisive threat to the family unit and to devoted



care providers will hopefully be eliminated by this new provision.

Our organization through the years has found that it is the exception rather than the rule when family interests do not support the vulnerable individual. It would impede the consumer empowerment process, however, if family members and care givers were to be directly involved with the commission. The advisory committee gives family members and care givers access to the system without giving them control.

It is still our belief that all disability groups should be represented by consumers, including those with neurological disabilities. Making this one group an exception is discriminatory and could lead to other exclusions in the future.

1630

We feel all disabled individuals should have access to advocacy. Any designation will be a problem for those individuals who have difficulty with identifying themselves as disabled, such as individuals with AIDS, and seniors who do not consider themselves disabled but due to problems of aging are in need of assistance. We feel that the moderate to severe change is not necessary and will lead to added confusion, excluding individuals who are still in need of the system.

We were pleased to see that non-instructed advocacy is now included in the Advocacy Act. We do not, however, agree with the very limited access to it.

We have people in our program who require advocacy on an ongoing basis. It is only with the ongoing monitoring of care that abuse can be prevented. We believe prevention is far better for the wellbeing of the individual than to wait until a life-threatening situation develops to take action. Many laypeople find the health care system intimidating. Calling an advocate in with this qualification could be viewed by both the family and the service provider as the least intrusive measure.

We believe that long-term advocacy in relationships that develop and enhance natural supports is the best way for volunteers to practise advocacy.

There is much good that can come from this new advocacy system, and we look forward to seeing this legislation becoming a law that will enhance our society.

**The Vice-Chair:** Is that all?

**Ms Jarcaig:** That's it.

**The Vice-Chair:** Any comments or questions?

**Mr Owens:** I'd like to thank the group for its presentation. You certainly touch on some issues that I have a deep and abiding interest in. The first is your point with respect to conflict of interest. We've had a number of presenters come forward and say there's an inherent conflict of interest by having service providers in fact doing the advocacy as well. In dealing with the Adult Protective Services Association of Ontario in the person of Trish Spindel, she's been quite eloquent in terms of that, as well as Patrick Worth from People First, in terms of his strong objections to service providers providing advocacy services.

The second and ongoing concern of mine is with respect to the non-instructed advocacy. I firmly believe we

need to strengthen that section in order to provide for quality-of-life issues as well. At the point where it reaches that a person's life is in danger or serious harm in fact a lot of time has passed, and perhaps it's too late at that point and it doesn't matter whether the person is in group home, in a private residence or a nursing home. These quality-of-life issues need to be addressed so that our most vulnerable citizens are able to lead as productive and challenging life as possible.

**Mr Gary Malkowski (York East):** Thank you for your presentation. Not only your group has raised a concern, but other groups have talked about the exception for the neurological category. I'm just interested. Do you feel that it is important for us to consider removing subsection 15(1), specifically the exception referred to in paragraph 6, to allow people with neurological problems to be involved?

**Ms Nola Millin:** Yes, it's very important.

**The Chair:** Any further questions or comments?

**Ms Carter:** Just following up on Mr Malkowski's question, if there were a provision in there that as soon as any group managed to develop an organization of 20 consumers or more, which is I guess the provision for the other groups, they would be represented on the appointments commission, do you think that would solve the problem?

**Ms Jarcaig:** Yes.

**Ms Carter:** As far as non-instructed advocacy goes, as you say, we have gone quite some way with the amendments to open that up. If somebody is in danger, an advocate can draw attention to this and can do something about it. What, in detail, do you feel should be done to extend advocacy? Would it depend on a person being able to make his or her wishes known by some means or other, or would we say that an advocate could intervene if a person appeared to be being neglected or not treated right, or whatever, regardless of whether he or she could communicate, even though it wasn't an emergency?

**Ms Jarcaig:** I know within our programs—and we have volunteers who go into institutions and deal with people who require ongoing care—it's the monitoring of that care, the person coming in there on a regular basis and seeing that the person is receiving the proper kind of care, that prevents any kind of abuse from happening.

This can easily be done by a volunteer. You don't need a tremendous amount of training for it. It's just like any family member who comes in on a regular basis and sees that mom was fed her dinner and has been taken to the bathroom on a regular basis and those kinds of things. But if there is no one there, that's when the abuse takes place.

**Ms Carter:** And of course we do accommodate voluntary advocacy in the act so that somebody who chose to perform that function would be empowered to do so.

**Ms Jarcaig:** That's right. But if that person is not capable of giving instruction, what we're concerned about is that the care providers in the institution will not feel that anything that advocate says is of any weight.

**Ms Carter:** So we need to broaden that.



**Ms Jarcaig:** Yes, that's what we feel.

**The Chair:** On behalf of this committee I'd like to thank you for coming in this afternoon and giving us your presentation. We appreciate it.

Seeing no further business before the committee this afternoon, we'll adjourn until 10 tomorrow morning.

The committee adjourned at 1639.

**Substitutions / Membres remplaçants:**

- \*Cordiano, Joseph (Lawrence L) for Mr Mahoney
- \*Owens, Stephen (Scarborough Centre ND) for Mr Wessenger
- \*Sterling, Norman W. (Carleton PC) for Mr Harnick
- \*Sullivan, Barbara (Halton Centre L) for Mr Chiarelli
- \*Wilson, Jim (Simcoe West/-Ouest PC) for Mr Runciman

\*In attendance / présents

**Also taking part / Autres participants et participantes:**

Auski, Jutta, senior consultant, policy development branch, Ministry of Health  
Fram, Steve, counsel, policy development division, Ministry of the Attorney General  
Malkowski, Gary, parliamentary assistant to the Minister of Citizenship

**Clerk / Greffière:** Freedman, Lisa

**Staff / Personnel:** Swift, Susan, research officer, Legislative Research Service



## CONTENTS

Wednesday 12 August 1992

<b>Advocacy Act, 1992, and companion legislation</b> . . . . .	J-189
Ontario Association of Children's Mental Health Centres . . . . .	J-189
Dr Xavier Plaus, executive director, Robert Smart Centre, Ottawa	
Suzanne Stamper, assistant director	
Advocacy Centre for the Elderly . . . . .	J-194
Judith Wahl, executive director	
The College of Physicians and Surgeons of Ontario . . . . .	J-198
Dr Michael E. Dixon, registrar	
Dr Rachel Edney, president, college council	
Dr George H. Morrison, past president	
Bala Nambiar, senior public member, college council	
Ontario Hospital Association . . . . .	J-202
Dr R.J. Brian McFarlane, chairman-elect	
Carolyn Shushelski, senior legal counsel	
Ontario Psychiatric Association . . . . .	J-207
Betty Bangay	
Jennifer Bangay	
Dr Brian Hoffman, psychiatrist	
Ontario Nursing Home Association . . . . .	J-213
Deborah Wall-Armstrong, vice-president	
Fran Bouchard, nursing home administrator	
Ontario Psychiatric Survivors' Alliance of Metro . . . . .	J-216
Shoshannah Benmosche	
Psychiatric Patient Advocate Office . . . . .	J-218
David Giuffrida, acting provincial coordinator	
Ontario Dental Association . . . . .	J-224
Dr Peter Fendrich, president	
Ontario Society of Paediatric Dentists . . . . .	J-229
Dr Jack Maltz, president	
Dr Paul Andrews, secretary-treasurer	
Citizen Advocacy Windsor-Essex . . . . .	J-234
Shirley Jarcaig, managing director	
Nola Millin, president	

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J-15



J-15

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## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Thursday 13 August 1992

### Standing committee on administration of justice

Advocacy Act, 1992,  
and companion legislation

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Jeudi 13 août 1992

### Comité permanent de l'administration de la justice

Loi de 1992 sur l'intervention  
et les projets de loi  
qui l'accompagnent



Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
Greffière : Lisa Freedman

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### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

### **Index inquiries**

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### **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Thursday 13 August 1992

The committee met at 1015 in committee room 1.

### ADVOCACY ACT, 1992, AND COMPANION LEGISLATION LOI DE 1992 SUR L'INTERVENTION ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervenants en faveur des personnes vulnérables; Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne; Bill 109, An Act respecting Consent to Treatment / Loi concernant le consentement au traitement; and Bill 110, An Act to amend certain Statutes of Ontario consequent upon the enactment of the Consent to Treatment Act, 1992 and the Substitute Decisions Act, 1992 / Loi modifiant certaines lois de l'Ontario par suite de l'adoption de la Loi de 1992 sur le consentement au traitement et de la Loi de 1992 sur la prise de décisions au nom d'autrui.

**The Chair (Mr Mike Cooper):** I call this meeting of the standing committee on administration of justice to order. This is the final day of public submissions on the advocacy package.

#### ONTARIO MEDICAL ASSOCIATION

**The Chair:** I would like to call forward our first presenters, from the Ontario Medical Association. Good morning. Just a reminder that you'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourselves for the record and then proceed.

**Dr Ian Warrack:** I am Ian Warrack. I am still a general practitioner from Vanier. I'm also the chair of the board of the OMA. With me today are Dr Ted Boadway, who is director of health policy at the OMA, and Barb LeBlanc, who, as we mentioned the last time, is really the brains behind this presentation.

We appreciate the opportunity to speak to the committee a second time and address some of the key issues as we see them regarding the amended legislation.

First, I would like to commend the government on the introduction of substantial amendments to the legislation. We believe the amendments address some of our most significant areas of concern. Naturally there are still areas that we're not entirely comfortable with, but we are confident that if government continues to listen and respond to

carefully considered criticisms and suggestions for improvement, we'll ultimately achieve our mutual goal, which is legislation that empowers and protects vulnerable and incapable adults without erecting undue obstacles in the care and treatment provided by caring families and well-intentioned health practitioners.

The Ontario Medical Association has been very interested in the development of this legislation, as you probably know, and in fact discussed the acts extensively at its annual general meeting of council. The OMA council, which is basically our parliament, gave us clear policy directions in support of the empowerment of vulnerable persons in making treatment decisions, clarification of the rules surrounding consent to treatment, and the making of advance directives in support of future health care decisions. Those principles have subsequently been embodied in our recommendations on the three pieces of legislation.

Before we begin to discuss the problem areas we still see with the legislation I'd like to briefly identify some of the positive amendments from our perspective.

Probably the biggest improvements from the practitioner's perspective are the amendments to the emergency treatment provisions under the consent act. They are now much more practical. The expansion of the definition of "treatment" to include a "plan of treatment" is also very helpful. And under the Substitute Decisions Act, we feel the introduction of expedited powers of attorney is a significant move forward in ensuring that a person's capable wishes are faithfully executed in the event of later incompetence.

The OMA's comments today will be based on two fundamental principles: fairness and practicality. It's critical that the legislation reflect both of these concepts throughout or it's destined to fail.

We will confine our remarks to a relatively few issues today. Our written brief, which I hope you have, provides a more comprehensive discussion of our concerns and our suggestions for improvement of the legislation.

**Dr Ted Boadway:** As Dr Warrack has said, we will address a few key issues today, those being access to records, requirements for rights advice and reliability of wishes. We will also comment more generally on the age provisions under the consent to treatment legislation and the way psychiatric care is handled under the bills.

The Advocacy Act permits access to records under a variety of circumstances: with consent of the person; without consent, if the person is deemed to be at risk of serious bodily harm; with consent of a substitute decider, where the person is incapable of consent on his or her own behalf; and with the permission of the Advocacy Commission if the records are required in the pursuit of systemic advocacy.

This access appears to put vulnerable people at an unfair risk of having their personal medical information violated.



It also places an impractical onus on practitioners to ascertain the validity of these requests for access.

Access to health information is a major concern to physicians. Our code of ethics demands that we hold our patients' health information in confidence, and breach of this trust is grounds for disciplinary action at the regulatory college.

Physicians are inundated by requests from various third parties for access to medical records. These run a gamut and include families, insurance agencies, lawyers, other health professionals, and government agencies such as the Workers' Compensation Board, to name just a few. To give you some idea of the volume we are talking about here, I will say that the average GP probably gets about 40 to 50 of these requests per week.

It's interesting: Ian and I were discussing this on the way over here this morning, and Ian thought that in his own personal practice the number might be closer to between 30 and 40. I think it depends a little bit upon the nature of your practice, but it's a great number. Also, at the Ontario Medical Association we get a great number of requests for help and information from doctors who are confused by what they should and should not release, and to whom under what circumstances. It's a very serious problem out there for practising doctors. We believe that the provisions under the Advocacy Act will guarantee confusion as they stand at the present time.

This act does not seem to require that an advocate identify the source of his or her authority to examine any particular record, and further, does not require any independent authorization for access. Advising physicians on a continuing basis on what authority they have to have before they can actually release information is the kind of advice we have to give many times a day to physicians around the province. Physicians will, therefore, have no reasonable grounds upon which to refuse access and will have little option but to acquiesce when faced with some of these requests. In addition, since the rules governing information which may or may not be accessed are unclear, it is likely that the medical information may be inappropriately released.

The OMA has serious concerns about the position in which it places our members and our ability to give them wise advice. We believe there must be a clear authorization for access to records and that this should probably come from the judiciary.

**Dr Warrack:** The second area we'd like to discuss today relates to the circumstances under which rights advisers must be contacted.

The amendments under section 10 of the Consent to Treatment Act appear to be an attempt by government to make the provision of rights advice more practicable. Unfortunately, this amendment still requires further clarification.

The requirements regarding rights advice following a finding of incapacity vary depending on a number of factors, including where the treatment is to occur, whether or not the treatment is a controlled act, and whether the person objects to the treatment.

This will really prove to be very confusing to practitioners. They'll not understand why they have different

obligations and requirements for the same treatment depending on whether they're in their office or in a designated health care facility. In addition, the OMA believes that the location of treatment will become increasingly meaningless as greater numbers of procedures are carried out in the community and in home settings.

The OMA recommends that the reference to place of treatment in the act be removed and that the requirements for rights advice relate to the treatment proposed and whether the person has any objection to it. Consent or refusal would then be obtained from the substitute decision-maker.

We believe that this recommendation is in keeping with the thrust of the Regulated Health Professions Act, which identifies invasive procedures and those that pose risk to the person as "controlled acts" and places specific regulatory restrictions on them.

It also permits necessary medical care to occur without delay for non-objecting persons, based on the authorization of their substitute decision-maker.

If the rights advice process is to be effective, it must be seen by physicians to be fulfilling a genuine need; otherwise it will be viewed only as a bureaucratic roadblock to good patient care.

**Dr Boadway:** A third area of OMA concern is a practical one relating to the reliability and validity of previous wishes. This legislation permits wishes to be expressed in a number of ways, some of which are quite formalized and others which are not.

Questions arise as to the reliability and validity of wishes whenever a practitioner receives this information indirectly. In some circumstances, for example, when the person has executed a power of attorney for personal care, the physician can proceed with a fair degree of assurance that the instruction is a true reflection of the person's wishes. However, when the practitioner must rely on hearsay, the degree of confidence is significantly less. This confusion is compounded in the event that oral instructions relayed by a third party contradict any written instructions available.

While the OMA has no desire to see people irrevocably bound to their written instructions, we believe that the legislation, as drafted, fails to provide adequate protection to incapable persons whose instructions may be misrepresented by unscrupulous family members or, more likely, by misinformed family members or by members of the family who are confused by the emotion of the moment. Very frequently these circumstances are emotionally stressing in an emergency situation, and just what is the proper thing?

It also places physicians in a difficult position by casting doubt on the strength of the consent upon which they are to act. This is particularly important in the event that there is disagreement among the family respecting the treatment and an action may be launched against the physician. I must tell you that disagreement among the family is not a rare thing whatsoever, particularly in emergency situations where the family doesn't have time to work it through as a family unit.

The OMA recommends that for clarification the term "wish" be defined in the act and that there be a requirement



that the person giving or refusing the consent have first-hand knowledge of the wish that is being relayed.

**Dr Warrack:** The next area that we'd like to address is more general and relates to the portrayal of mental illness and treatment for mental illness throughout the three pieces of legislation. There are clauses in each of the acts which specifically separate mental health from the rest of health care. Examples include admission to a psychiatric facility, treatment of a mental illness as defined in the Mental Health Act and different standards respecting the privacy of psychiatric and non-psychiatric information held by an advocate or the public guardian and trustee.

The OMA believes it is completely inappropriate to foster public fear of mental illness and mistrust of psychiatric care through the introduction of legislation that segregates one facet of health care from all others. If government truly wishes to introduce progressive legislation, it will reconsider the tone it sets for provision of mental health services and move towards bridging the artificial gap created between mental and physical health.

**Dr Boadway:** Perhaps one of the last items we would like to comment upon relates to the age provisions under the Consent to Treatment Act. I understand that the committee has been assailed with requests to return to the original presumptions of capacity and incapacity over and under 16 years of age. Although there appears to be no easy answer here, the OMA believes, and continues to believe, that relying on the common law is a good starting point. In any case, the OMA is pleased to offer whatever assistance we can to address this problem in a manner that most appropriately meets the varying health needs of adolescents.

**Dr Warrack:** Before I close, there's one thing which isn't down on the script which I would like to talk about, because I do a significant amount of work in nursing homes. That's under Bill 108, subsection 65(2), regarding a change of residence. Basically, what it says is that a guardian may not change the incapable person's residence to a more restrictive setting without agreement from the public guardian and trustee and the person's continuing power of attorney for property.

I'll tell you that quite often we have people who tend to wander, particularly in a nursing home setting. As they develop that trait, there have to be some restrictions that are applied on them which prevent them from doing that, because in fact what happens is that they will often run into their own personal problems. They'll run into physical danger. The real problem is whether or not the PGT would be able to respond in adequate time to prevent that happening. What I'd like to see is that there's some kind of timely response from the PGT to ensure that when people are at risk, we can maintain their safety.

Anyway, in closing, I'd like to reiterate our support for the work done by government to date in response to identified flaws in the legislation.

We hope that this second round of hearings will bring about equally significant but, hopefully, fewer amendments and they'll enable us to effectively empower and protect vulnerable and incapable adults.

I'd like to thank you for your attention, and obviously we'd be pleased to respond to any questions you might have.

**The Chair:** Thank you. Questions and comments?

1030

**Mr Alvin Curling (Scarborough North):** I want to thank you for your excellent presentation. The fact is that this thing is so wide that you, I notice, focus on just some specific areas. I'm sure if you had had more time you'd have gone into more.

Looking at this, actually, as you read, I was looking at page 4, just in the middle, in the centre of it, where you talk about disagreement among the family respecting the treatment and an action is launched against the physician. Then you mention something about the time factor in this, that sufficient time should be given in order to assess and to understand the decision being made by the vulnerable person. Sometimes the family itself would have had, as you said, a very short time to make these decisions, and as soon as that has been refused, the advocate then, if that process has gone through—do you think there was adequate time in which the advocate himself could assess that decision? I think they have a seven-day period or so in which they have to make that decision.

**Dr Boadway:** To be honest with you, sir, I don't think I understand your question, okay? I'm sorry.

**Mr Curling:** That's fine. Let me try again. If I heard you correctly, I heard you say that at times the families have to make the decision, and it's a short time in which to make quite a few decisions as to whether or not they should go ahead and the doctor should go ahead and do whatever he has to do. Now, if the person refuses treatment and then the other process clicks in where the advocate would have to come into place and they have to get another decision to be made, do you feel there is sufficient time where the advocate himself can understand the position and understand the situation enough in order to make that decision for that vulnerable person?

**Ms Barb LeBlanc:** If I could maybe just make a comment, I think the real answer there depends on the training of advocates, and presumably the processes in place will ensure that they have the expertise and the understanding that will enable them to make those quick decisions.

**Mr Curling:** Good. Because that's the point I wanted you to raise instead of my raising it. The training process of advocates, have you examined that and are you comfortable with what is being presented as what training would involve for an advocate and who will be trained in these instances—in other words, the qualifications of these advocates and how the selection process would be? Because you yourself would be assessing, as a doctor, whether or not this advocate understands or is capable of understanding the complexity of that no or that yes within that vulnerable person who is saying that.

**Dr Boadway:** I can't answer that, simply because I don't think we understand what the real training process will be. We don't have any clear understanding of what will truly be there, so I just simply have to trust that once



the training process comes in, it will be adequate and there will be opportunity to have input into it.

**Mr Curling:** Do you feel that the government itself should be in touch, especially with doctors, physicians, practitioners, about the training program for advocates before it is put in place—in other words, that it should be shown, before that is put into the regulation, to say, “Here are the procedures for training”?

**Dr Boadway:** Inasmuch as physicians will have to interact with those people a lot, it's important that whatever is constructed is constructed in a way that a useful interaction occurs. I think that if you don't ask the people with whom you're going to have to interact how it might happen, you might make a mistake. So hopefully we'll have some input into it. Quite frankly, there's much of it that's none of our business, but some of it will be our business because it will be having to interact with our frame of reference in our place of work.

**Mr Curling:** You're saying it may be none of your business, but I think it's going to be, as you said. If you as a doctor, as a physician, knowing exactly how important it is for, say, proceeding with some operation, and this vulnerable person says no and then goes through the process of this also, all the individual will do is translate to say, “I think when that individual says no he means no,” and you're saying, “I don't think that you do understand the consequences of that no.” So therefore the question you're going to ask is, is this advocate capable enough to comprehend what that no is? So therefore you, as a physician, are a part of that in the oath you've taken to serve and to save lives, and you're saying this could cause death itself.

**Dr Boadway:** Yes, you're absolutely right. This is in the area of our medical expertise and these are the areas where we hope we'll be listened to extensively, because that is what we're trained to do. When it comes to areas of medical expertise, we hope they'll be accepted as a significant amount of input.

**Mr Curling:** The next point I would like to turn to is on page 2, although it is not quite the same way the dentists have put it, that “This access appears to put vulnerable persons at an unfair risk of having their personal medical information violated.” In this other part, “It also places an impractical onus on practitioners to ascertain the validity of these requests for access.”

Although I'm not speaking about access—I don't want to make the point about access to information—many of the dentists who came in yesterday spoke about putting the onus on them to make certain decisions. I'm not quoting verbatim, but I think he stated that he didn't want to be a social worker in all of this and the onus that is placed on him to make decisions is too much.

Do you find yourself, because of these bills, this legislation, coming more to making decisions for family and doing the paperwork, the follow-through, all this process that the advocate—is there more paperwork for you? Is there more social work for you?

**Dr Boadway:** It's not so much social work; it's a matter of trying to decide what is the right thing to do under these rules. I have to tell you that we've had the opportunity to

spend a lot of time working on the procedure through which one will have to go to release information as a practitioner. We have had the luxury of that. Most practitioners haven't had that. We think it will be very difficult for doctors to sort it out. We're having difficulty sorting it out. Every time we work through it, it seems we find another wrinkle, and we've been through it now for months. We think the probability of getting our members out there to understand how to do this just right is very low; we're quite pessimistic about that. So the chance of confusion and records being at risk because of people making mistakes is, we think, increased. That's our concern because we're having a lot of difficulty grasping all of the nuances of what one should and should not do and when.

**The Chair:** Mr Malkowski on some clarification.

**Mr Gary Malkowski (York East):** Just a point of clarification. I think it might be helpful for members to have the role of the rights adviser, if the Ministry of Health's policy person could clarify this.

**Ms Jutta Auksi:** I was just afraid that perhaps in Mr Curling's question there might have been some slight misunderstanding raised about what the role is of the rights adviser, who of course in the previous version of the bill was called the advocate.

Of course, that rights adviser does not make a treatment decision. The role of the rights adviser is simply that if a person is found incapable, in those limited circumstances now under the bill where the rights adviser would meet with a person, the role would be simply to explain to the person that they have a right to have the finding of incapacity reviewed. It doesn't really relate to whether the person decides yes or no; it relates to whether they are disagreeing with the fact that they were found incapable and that the decision is removed from them.

So your response actually was okay in that I didn't get the sense that you misunderstood, from the comments you made in response to the question. But I just wanted to make sure that the committee members and yourselves weren't somehow misled.

**Mr Curling:** I would like to comment on that. I'm saying that in all the forums to advise anyone, they must understand the complete issue, and when the vulnerable person says no, the rights adviser has to understand—the person said no, and did he understand the process itself? I'm not saying they are going to make the decision. You answered correctly, yourself.

**Mr Jim Wilson (Simcoe West):** Thank you very much for your presentation again before the committee this morning. I just wanted to say briefly that we're very sympathetic to your concerns with regard to access to records. We put the government on notice with respect to that, and we're prepared to introduce amendments if between now and the clause-by-clause hearings we don't see some government amendments that address those concerns.

The same goes with regard to the recommendation that rights advice relate to the treatment provided. The comments you've made this morning make absolute sense to me.

I wanted to ask you to clarify two sections dealt with in your oral presentation. One is the different treatment of



mental illness with respect to other facets of health care. Also, I really don't understand what you're trying to get at with respect to age 16 and the question of capacity. I think your paragraph there and your comments are extremely general, and it might be more helpful if you could be specific there.

1040

**Ms LeBlanc:** If we start with the issue of mental health, that was really just a general comment that was designed to reflect some comments we've had from our membership, particularly psychiatrists, on an ongoing basis, for years. At this point, we have an opportunity to change some long-standing attitudes. Unfortunately, instead of presenting us with an opportunity for improvement, this legislation seems to foster some of those old stereotypes.

**Mr Jim Wilson:** You use the word "progressive" in your brief, and we've been told it is regressive in the area of mental illness. Is there a section in your more detailed written brief that would point out some of the regressive measures?

**Ms LeBlanc:** Actually, in the written brief, rather than dealing with it as a global issue, we have, at a clause-by-clause level, identified areas where we thought changes might be appropriate.

**Mr Jim Wilson:** I'll be sure to read that.

**Dr Boadway:** To respond to your question about age, you identified the fact that I was vague there. You're right. You see, we have wrestled with this age thing for years as a profession, and we know it's a real problem for everybody here, so we're all in this.

What was identified to you were problem areas for kids who would be disadvantaged by the choice of an age. I think that by changing it in the way it's done, you've actually looked after the problems of a huge number of kids; it's been very helpful for those. So if you take most family doctors facing most kids, you've done an awful lot for them. But you're left over with a group of kids whom it disadvantages, changing it this way. It's a smaller group and it's mostly those children who have serious problems that are usually of a psychological or a psychiatric nature or who are mentally distressed and therefore temporarily disadvantaged in their decision-making. They are in fact disadvantaged by this change.

I think you've looked after our largest problem, but you've left a small nub who are a little worse off than they were.

In the past, what we've asked doctors to do is exercise good common sense and reason, and there isn't a day that goes by when we don't get a request from a doctor somewhere between Windsor and Ottawa and Kenora who's asking about this. We get phoned about it all the time. We ask them to exercise good common sense and judgement when faced with kids. That's a difficult position to put them in, but I think that's what works because there is a body of common law out there which helps give direction and the body of common law has built up over a period of time, so we're able to advise them about that.

If you make the rules the way you've made them, there are several ways you could think about looking after that

small group of kids who are left disadvantaged. You could think of making exceptions which would try to address them in particular. You could except it by place of treatment. You could except it by nature of illness. We don't like that in other settings—in fact, we've spoken against it in our brief, so you could accuse us of coming and going at the same time; I'm sorry, but this is very difficult and that's what happens—or you could do it by professional status. We don't think that would fly anywhere. But there are different ways you could make exceptions.

I don't think up to now you've carefully focused on the nature of that group and the exceptions that could be made. So perhaps if you take this as the right starting point—and I think it just about is—and if you focus on those kids and then look at what you could do to help them out particularly, you might find a package of exceptions which could address their needs.

**Mr Jim Wilson:** Was the OMA more comfortable with the original draft of the legislation?

**Dr Boadway:** No, we're more comfortable with it this way. This is a big improvement.

**Mr Jim Wilson:** You're more comfortable with this. I just wanted to get that clear in my mind.

**Mr Norman W. Sterling (Carleton):** I just have one question with regard to your statement about clarification of the term "wish," that it be defined in the act as someone having firsthand knowledge of the wish that is being relayed. What do you mean by "firsthand knowledge"? Are you saying hearsay but only one step away from hearsay?

**Ms LeBlanc:** Yes, actually. I guess so, if you look at it that way. What we were talking about there is that rather than "He said that she said that the person wished," it would be that you, as the substitute decision-maker, have heard directly from the person that that is in fact their wish.

**Ms Zanana L. Akande (St Andrew-St Patrick):** Thank you very much for your presentation. We have received presentations from various groups that have been quite interested and quite determined around the issue of time being of the essence in terms of medical information, physicians feeling they must have an opportunity to provide the right treatment for the patient immediately and therefore concerned about the transfer of official records and the speed at which that kind of information and direction is achieved. Yet when I look on page 4 of your presentation, I'm concerned about your fourth paragraph, where you say "questions arise as to the reliability," almost to the point where sometimes the physician may be—you used the word—getting information more like hearsay.

Are you suggesting by that that you would want something much more official like a copy of the previous direction of the patient, if it's that type of situation, or that you would like to hear directly from the substitute decision-maker, if that's the situation?

**Dr Boadway:** If I could just step back one step from your question, I tried to put myself in the situation of having a person who's ill and who is incapable him or herself and having a written directive from them, which they may carry on their person or get to me some other way, and then I have somebody else who says, "I think they



want—" and what they suggest is something diametrically opposed to what the person has written, and now we have to do something in the next however many minutes or hours. It's a real pickle to be in on a Saturday night, because what do you do?

What we're trying to find is as direct a way as possible to bring that information and give our members some idea how they can judge which piece of information to pay attention to, because they do now have to decide, "Am I going to pay attention to this or am I going to pay attention to them?"

What we're suggesting is that if it's first hand, that is, if the person can say, "The ill person said to me they wanted this written thing overridden," then that's fairly direct. The more remote it becomes, the less I can trust the fact that it's what the person really wants. We're looking for as close and as clear a set of directions to practitioners in assessing which kind of information to pay attention to. That's what we want.

**Ms Akande:** It would seem, if it is a previous direction and it is written and signed, that would take precedence. However, I can understand your dilemma. I'm receiving that and I thank you for it.

The one other thing I wanted to mention is that in this legislation, Bill 109, the only real age that is referred to is in subsection 10(4): "A health practitioner who finds that a person who is 12 years of age or more is incapable with respect to a treatment shall ensure that a rights adviser is notified of the finding if," and then a set of circumstances. I inferred from the remarks you made that you were assuming that much more definitive statements were made about the age below 16 than that.

**Dr Boadway:** No. We understand that. That's why we think it's so much better than it was.

Shall we add more to that or shall we leave it at that?

1050

**Ms LeBlanc:** No, that's okay.

**The Chair:** Thank you, Ms Akande. One minute, Mr Winninger.

**Mr David Winninger (London South):** I would direct your attention to clause 24(2)(b) so that we're clear that access without the consent of the patient to the records is only where there is a risk of serious harm, so it's not on demand, as it were; second, that where access is sought to confidential records for purposes of systemic advocacy, personal identifiers will not be released. That's a second caveat.

Also, I wanted to put to you a question. You mentioned that you wanted to ensure that there would be timely response on the part of the public guardian and trustee in these cases where a timely response is certainly required. I was going to ask you whether you had any idea as to what might be a reasonable time for a response so that we could take that into account.

**Dr Boadway:** In the one you haven't had an opportunity to read, which is our more complete brief, on page 21, that was one suggestion, a timely response. The other is to shift the inertia. Systems have inertia built into them. If you have inertia working against you, it's just a continual

uphill battle. If you put inertia on your side, then things go with you rather than against.

When the legislation is worded such that you have to have—if you look on page 21 of our brief, the first paragraph says, "A guardian may not change the incapable person's residence to a more restrictive setting without agreement from the PGT." You have to actually get it. Well, I'm sorry, but the way the PGT works, you might get it in 11 months.

So what we're suggesting, over on the next page, is that the guardian of the person shall advise the PGT of any decision to change so that the PGT knows, can oversee, and can intervene if they find a problem, but you can act and get it done. Then, in a particular setting, the PGT could say, "You folks are not doing this very well. I've looked at 10 of your cases and I'm really unhappy with what you're doing here," and they could come and take corrective action.

**Mr Winninger:** Would that not be cumbersome and cause some detriment to care if you move someone and then they have to be moved back again?

**Dr Boadway:** It's not as much a detriment to care as when you have people who are wandering on the first floor of your nursing home and you can't transfer them to the second floor, which is your secure part of the nursing home, because their mental state is deteriorating. Your problem is you have to get those people into a secure facility. Their biggest risk is wandering out on to Steeles Avenue.

**The Chair:** Thank you, Mr Winninger. Dr Warrack, Dr Boadway and Ms LeBlanc, on behalf of this committee I'd like to thank you for taking the time out this morning and giving us your presentation.

Before our next presenters, Mrs Sullivan.

**Mrs Barbara Sullivan (Halton Centre):** We have before us letters from the minister—actually, not even from the Minister of Citizenship but an acting executive assistant to the Minister of Citizenship—a letter from Howard Hampton, the Attorney General, and a letter from the acting executive director, assistant to the Minister of Health, indicating that none of those ministers will be able to appear before the committee in clause-by-clause—or at any other time, it appears, in the case of the Attorney General.

It has been our contention for a long time, and Mr Sterling has raised this issue on more than one occasion, as I have, that the ministers involved do not seem to be taking their responsibility with respect to carriage of these bills and their legislative responsibility in any way seriously.

Once again today we have no legal representation from the Ministry of Health, nor is the parliamentary assistant to the Minister of Health here. We've had clear indication all the way along as we've asked for interpretation of policy and information from the parliamentary assistants that there is no freedom available to the parliamentary assistants to commit to adjustments of the words, as they've been presented in the act, for greater clarity, and it's very clear that this is simply going to continue as these hearings proceed.

I am going to place a motion before the committee that the Chairman of the committee be directed to write to the House leaders to request a change of sitting dates for clause-by-clause to enable the ministers to be present



while clause-by-clause is being conducted. The clear abrogation of ministerial responsibility is beyond belief in the question of these bills.

These bills, as we know, affect every single person in Ontario with respect to the consent to treatment bill, many people in Ontario with respect to the substitute decisions bill and the most vulnerable people in Ontario with respect to the Advocacy Act.

It seems to me that the ministers should at least indicate that they have some interest in watching the progress of this legislation, in working with the committee to make the legislation better, to make it work. Every single health professional in Ontario is affected by this legislation in every single community and the Minister of Health has deigned to allow her presence to come before us on one occasion. Frankly, it's not good enough and in my view if the ministers aren't interested in this legislation, why should the opposition be?

I am asking now by way of motion that the Chairman contact the House leaders for permission to change the sitting dates of clause-by-clause to enable the ministers to be present so that they can deal with the legislation for which they have legislative responsibility.

**Mr Sterling:** I was also intending to move a motion and I was going to do that probably at 12 o'clock so that we wouldn't interfere with the witnesses, but notwithstanding that I want to indicate my support for Mrs Sullivan's motion.

I think it is even more critical because of what the opposition parties have agreed to do, trying to be as constructive as possible, as we can be with Bills 74, 108, 109 and 110. We have agreed to limit the time for committee of the whole House back in the Legislature, when we would hope that we would have the ministers present, in order that these bills can be passed and we can get on with clarifying what in fact the law is in this area.

I had fully expected, in agreeing with my House leader that this was an acceptable route for us to do in terms of saying, okay, we were going to be reasonable in the time that the Legislature was going to take when this legislation goes back, that the ministers would have been here for clause-by-clause consideration of these bills. Now we find that we are not going to have the ministers present here for clause-by-clause consideration, and we are never sure that the ministers are going to be in the Legislature when clause-by-clause consideration is done in committee of the whole House.

We want to drive home some points and we think there are very significant defects in this legislation at this time. Therefore, I agree with Ms Sullivan. My motion would have said we postpone all consideration of clause-by-clause until the ministers can appear.

**Mr Winninger:** I'd like to respond as well to the comments made by Ms Sullivan. First of all, everyone's cognizant that the role of the parliamentary assistant is in part to steer these kinds of bills through committee, and that includes clause-by-clause. Ministers have appeared before this committee on these bills. The number of amendments, which the opposition mocked, I think attests

to the responsiveness with which the ministers greeted the concerns expressed by the opposition members and expressed by many of the fine presenters we've had over the course of the first set of hearings, and now the second set of hearings. Certainly, meetings will take place to discuss any further amendments that may become necessary.

I don't know why the opposition parties are insisting on having the presence of these busy ministers, particularly when they have such other responsibilities as cabinet retreats, when we agreed to two extra weeks of hearings because of the number of amendments and to give the public a fair opportunity to come back and respond to the amendments that have been put forward.

1100

I think it's very unfair to suggest that somehow the absence of the ministers from these hearings is suggestive of any disinterest on their part. I know they read Hansard and I know they read the written presentations with considerable interest.

I would certainly object, and I would ask my colleagues to object to the kind of motion put forward by the Liberal Health critic directing the Chair to request their presence or to request any change.

We have orders under the Legislative Assembly setting the time limits for the hearings and the clause-by-clause, and that was agreed to be four weeks and two weeks in between to allow any amendments to be prepared, if necessary.

I think this government has bent over backwards to accommodate the concerns of the opposition parties and I think it ill behooves the Liberal Health critic to come to the committee today and say, "Well, we're not prepared to proceed unless we have the ministers there."

**Mr Curling:** Having listened to Mr Winninger, I'm surprised that he made those comments. First, what I heard from you is that the minister's too busy to do her job. I'm hearing that for these legislations that are so important, you said it's not necessary for the minister to come, because if she comes—she's busy at cabinet retreats.

I have been in cabinet and I have carried through the passage of bills, like Bill 51, on which we travelled more so than with this bill. I was at, I would say, 98% of the hearings because it was so important that it was not second hand when the minister got it, because that what's we are elected to do. Then you're saying, what more can she do in that sense.

I feel the motion is quite appropriate. It goes in appropriateness with the fact that even when we were limited speaking in the House, we get an opportunity, here at committee, to question the minister and also to explain some of the statements that are made here or the bill here, the confusion. Each presenter comes before us, states emphatically that he or she is confused, that some of the things are vague and need some explanation, and we get different interpretations. Even when we try to get a second opinion outside of here, we get resistance.

I would say that the government should look very, very carefully and stop this blockage in order for us to dialogue properly, and get the minister in here so we can ask her some questions.



**The Chair:** Thank you, Mr Curling. It seems that we're going to be getting into quite a discussion on this and I was wondering if I could have unanimous consent of the committee to defer this until after the last presenter this morning, in fairness to our witnesses who are waiting. Do we have unanimous consent? Agreed. Thank you very much.

#### ONTARIO ASSOCIATION OF DEVELOPMENTAL SERVICE WORKERS

**The Chair:** I'd like to call forward our next presenter from the Ontario Association of Developmental Service Workers. Good morning. I apologize for the delay. Just a reminder that you'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Mr George Anand:** I'm George Anand. I'm the president of the Ontario Association of Developmental Service Workers. On my right is Mr Gus Collins, who's one of the executive members of our association.

I would like to thank the Chair and the committee members for the second opportunity to appear before the committee, to be able to make comments on these significant pieces of legislation.

Very briefly, at this particular time I would like to enunciate some of the most important principles that we presented on my first appearance before this committee. We strongly feel that these pieces of legislation have been on the drawing board for the last 30 years and enough significant discussion has taken place. Of course, these legislations are going to need fine-tuning, but in the meantime, there is a big vacuum that exists and that vacuum needs to be filled on an urgent basis. That kind of a vacuum is doing more disservice to the clients, to the service providers, to the families and to the practitioners.

What I suggested in the beginning was, let's go ahead and pass these pieces of legislation and then come back after three years and review these legislations from the point of seeing whether you can make them less legalistic, and then to have a common bureaucratic response to the certain overlapping areas on those three pieces of legislation and then hope to have a common bureaucratic response on certain overlapping areas.

Last time I was quite heartened to hear that one of the most significant communities are the ethnic communities, and those ethnic communities are the least organized and the least informed. What I understand is that their viewpoints would be taken into consideration so that they will have some fair representation on the advisory board on the Advocacy Commission. Since the last time we made the presentation, I've come to know the service providers, who are social service providers; we were glad to know that they will be playing a part on the advisory board. That was a significant step.

Further, we felt we are a growing organization of direct care service providers. We are the service providers who form the first line of support services to the so-called vulnerable individuals, and it is very significant. What we

found out from our experience is that if there are any gaps in service that exist at the other areas, it's left to the direct service providers to fill up those gaps, using their own ingenuity. But as a growing organization, we are making sure that our members are fully trained, have certain guidelines to see that the individuals whom they are working with are empowered to make more autonomous decisions on their part and to provide these individuals with the kind of support systems that are going to enhance them to lead a more enriching life.

We are concerned that with these new pieces of legislation, there are definitely going to be more demands. That's going to tax the resources of the direct service providers. We take the challenge, but at the same time we would also like to caution that there should be adequate resources there so that the service care providers, who form the first line of support systems, are not in the position where, by providing one side of support systems, they are overlooking the other side of support systems because of inadequate resources.

#### 1110

Adequate resources are a very significant area. There's going to be a very wide role for advocates in terms of systemic advocacy, the rights advocacy and the case advocacy. There should be adequate resources provided to the Advocacy Commission so that the advocates are able to fulfil their mandated role.

Last, in terms of commenting, yes, we were perplexed when we looked at the age thing. When we were going through the act, when we interpreted it, we felt that at one time maybe there was no age consideration and that the common law principles were going to be the most dominant ones. Then we looked at the consent to health act, and there we felt that the age of 12 years or more; then on personal care, we looked at the age of 16 or more.

We also felt that one of the major areas under which the decisions are going to be made is for the so-called vulnerable individual's ability to comprehend instructions, but then we felt there were certain emotional maturity levels that play a far more dominant role. It's quite comprehensible that a 10- or 11-year-old may be able to understand the instructions better than the 12- or 13-year-old. Again, what we felt was that the 12- or 13-year-old may be able to comprehend, they may be competent, but may not be emotionally mature enough to make certain decisions. Maybe that's the way we are interpreting.

We are struggling to understand, in terms of the different age patterns we are seeing, which ones we should be adhering to. We strongly feel that the emotional maturity consideration and sometimes the need to provide certain necessities to individuals for certain treatment considerations are some very significant considerations.

Once again, to repeat myself, we still believe very strongly that there has already been significant discussion on this business or legislation, but at this particular time, we feel that prolonging the conversation would be doing more of a disservice.

**Mrs Sullivan:** I'm interested in your proposal that there should be a review of the legislation in a specified time period; you suggested three years. Is your recommendation



to the committee that there be a clause included in the Advocacy Act that would require statutorily a review of that legislation within a specific time frame?

**Mr Anand:** Yes, we did make the recommendation. It should be seen, because it's a very new piece of legislation. Building up that kind of mechanism could very well be one of the ways, if those pieces of legislation are going to be reviewed after that period of time, to iron out the wrinkles.

**Mrs Sullivan:** Do we have time for a second question?

**The Vice-Chair (Mr Mark Morrow):** Yes.

**Mrs Sullivan:** You've indicated that you feel the effect of Bill 74 will be to place more demand on the direct service worker, and you're asking for additional resources for existing support services as well as for substantial resources for the Advocacy Commission. Many other groups and organizations have asked for a consultative process on the development of regulations and on the implementation, and we've had no information from the government or indication that this is the route it intends to go.

The feeling certainly is, whether it's health care or social services delivery, that these bills will create substantial change in the existing system, and I'm wondering if you support the position of the other groups that also demand a consultative process involving health care practitioners and others in an implementation process.

**Mr Anand:** Again, to be most candid, I think we still have to go through the process at this particular time to see exactly. This is one of the areas where we feel most probably there will be more demands placed, that of extra service providers, but to what extent?

Moreover, we also feel that the role and the responsibilities of the social service providers most probably would be going through some kind of change. It would be evolving; it would be something different from the kind of role they're playing right now. We're not quite certain at this particular time exactly to what extent the need is going to be. But what we'd like to be able to do is to provide guidelines to our members so that they are in a position to provide the adequate support systems to individuals. So far they have been able to use their ingenuity in terms of filling any gaps in service that have existed at some other end, but at the same time I think we will be keeping track of the extent and the degree of resources that are going to be needed. We are not quite certain at this particular stage, but we do have a feeling that most probably it is going to demand more resources.

**Mr Jim Wilson:** Following on what Mrs Sullivan just asked you in terms of resources, you began your presentation by saying that there's been enough debate—and you're right; it's gone on for many years—and that we should proceed with this legislation immediately. Then the question of cost and resources does come up. As you know, it's a non-subject here; we're not really allowed to discuss it at this committee because the government keeps telling us, whenever we ask any questions about it, "It's all under review and there's a study coming out." I don't know when; I guess after we pass the legislation.

To me that's irresponsible, and I can't justify that to my constituents. I don't know what riding you live in, but they'd laugh at me if I came to them with a package that didn't have costs attached to it in this day and age. It's one of the first questions they ask.

In light of that—and you mention a sunset clause, a review perhaps in three years—maybe a better preference would be to phase in this legislation and ask the government at a particular point, maybe six months from now or whatever, to tell us exactly what financial resources and people resources it is going to put into this legislation.

1120

**Mr Anand:** When we look at these three pieces of legislation, the substitute decision-making, the consent to health, the advocacy, they are so much intertwined with each other that we feel all three of them should be passed at the same time, because with the consent to health act, they are definitely going to need substitute decision-makers in certain situations, and they are definitely going to need the service of the advocates in certain situations.

Of course, in the administration and the day-to-day working of the consent to health act, if those resources are not there, I guess that's definitely going to cause a problem. We feel that all three of them should be passed at the same time.

**Ms Jenny Carter (Peterborough):** You raised the question of a review, and of course this act isn't cast in stone. Obviously, we shall be looking at how it works and what parts of it work better than others. I know of no plans to review it at a set date, but certainly that is something we shall need to bear in mind, so that is a helpful suggestion.

The question of resources: As far as the act goes, we are employing probably around 150 people to be advocates, and we're also incorporating volunteers. Obviously, it's assumed there is a network of social services there, otherwise the advocates wouldn't be able to help people because the bricks and mortar and the staff and so on wouldn't exist. But it seems to me it's not the job of these acts to deal with all that. That will come under things like the long-term care provisions and so on as to what accommodation is available to people with certain disabilities and so on. So I see that as being a rather separate question to what we're looking at as far as, certainly, Bill 74 and probably the others are concerned. Of course you're right that advocates won't be able to function unless the resources are there, but as I say, I don't see that that's a part of these acts or that it should be.

You raised the issue of the reduction in the age from 16 to 12. I think this is something that's been overemphasized. We haven't actually made a big change. My understanding is that we've just said that a person of 12 or upwards can get rights advice if they're declared incapable. Could we get some expert opinion on that which might enlighten you, please?

**Ms Auksi:** I should clarify that the reference to age 12 is not to change the previous version to say that there's a presumption of capacity at age 12; there isn't. What has been done is that all presumption of capacity or incapacity has been removed, the old section 8. The reference to 12 is



that it's at that point that if there is a finding of incapacity, then the person is entitled to certain rights information.

Section 10 sets out, if it's a controlled act in certain facilities and so on, at what level you'd actually get a meeting with a rights adviser if you want or if you object to the treatment. But the reference to 12 is only when the rights information kicks in, so there's no presumption of capacity or incapacity now in the bill.

**Ms Carter:** Does that help to clarify?

**Mr Anand:** It does to a certain extent, but as I understand it, those common-law principles are still going to be the most dominant ones we take into consideration regarding emotional maturity.

**Ms Auksi:** That is important too, and I think you alluded to that in your presentation: that there's no reason to think that the notion of capacity has to do with a certain IQ, for example, or only until actual development. Obviously, with young people, there is a certain maturational development involved; with people with mental disorders or emotional difficulties, there are certain other factors that must be taken into account.

We certainly would hope that in consultation relating to the regulations that are to be developed on the findings of incapacity there would be input from the health practitioners who would be making these findings to help to ensure that what needs to be in regulations to trigger some of this thinking in practitioners would be in place without getting into areas that get so changeable or so detailed that they would in fact hamstring the practitioners in making good judgement calls.

**The Vice-Chair:** Thank you very much, Ms Carter.

**Ms Carter:** Do I have time for one more point?

**The Vice-Chair:** Ms Akande would like to ask a question.

**Ms Carter:** Okay.

**Ms Akande:** Thank you very much. I wanted to ask again, because I'm not certain about your answer, whether your association would see itself as wanting to have a consultation process around the development of regulations which accompanied these bills.

**Mr Anand:** Yes, we would definitely like to be a part of them.

**Ms Akande:** I wasn't sure. I know Ms Sullivan asked that question; I wasn't quite sure of the response.

The other thing I'd like to refer to is, you have mentioned changes to the way in which your workers will operate. You have said that there will be more work. I want to know on what basis you feel that the change will constitute more work for your association members rather than different work or less work.

**Mr Anand:** That's one very good point. Definitely we can see the different roles and responsibilities that are going to be faced by our members. But at the same time, in view of this legislation, we can see the different kinds of demands we will face because of some of the practices that have been there in terms of behaviour modification, aversive conditioning etc. We agree that those particular modalities have been removed. We are very glad that no individual

rights or freedoms should be impinged upon in that manner without a certain due process. What we're saying here is that our members are definitely going to be able to provide more one-to-one care for those individuals who are facing those moderate to severe kinds of problems.

**Ms Akande:** All right. Then you do agree that it may well be that with the implementation of this particular legislation your workers may work differently but not necessarily more.

**Mr Anand:** Differently, we definitely feel, yes. We are in the process of laying down guidelines or preparing our members. There are going to be different responsibilities. It's a different kind of framework to work under.

**The Chair:** Mr Anand, Mr Collins, on behalf of this committee I'd like to thank you for taking the time out this morning and giving us your presentation.

1130

#### EASTER SEAL PARENT ADVOCACY COMMITTEE

**The Chair:** I'd like to call forward our next presenter, from the Easter Seal Parent Advocacy Committee. Good morning. Once again, just to remind you, you'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you'd keep your comments to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Mrs Ludmilla Donald:** My name is Ludmilla Donald and I'm a parent of a disabled child. I'm also the chair of the Easter Seal Parent Advocacy Committee. You heard from the Easter Seal Society earlier this week, I believe. We are a committee of parents who have been spawned and sponsored, in effect, by the Easter Seal Society. We are a volunteer group. We are certainly not funded to do any extensive analysis of these bills and therefore we have focused our concerns on Bills 74 and 109. We have not, unfortunately, had the opportunity through our own limited resources to be able to do an in-depth analysis on every section. Therefore, my comments will be on the selected sections that most disturb us.

We represent parents of 7,900 physically disabled children and youth in Ontario, and our submissions are also confined to those children who are under age 16. We filed written submissions on September 26, 1991, which outline in depth and in much more of a narrative way the difficulties faced by families and children we represent. We were here in February and presented oral submissions and a brief written submission to this committee. I hope you ladies and gentlemen have received the synopsis of my comments today. They are dated August 13. I will follow fairly closely what is in the written submission.

We are very disappointed that Bill 74 still does not give systemic advocacy to children under 16. This is the item that we are most concerned about as parents of these children and that we believe is required to the greatest extent. If this government were going to do anything for these



children, we would have suggested that systemic advocacy in some form be provided.

The amendments to Bills 74 and 109 do not rectify or even address the root problem of the legislation—namely, that it applies to the majority well-treated population of children under 16 extraordinary and invasive procedures which are more appropriate to those children who suffer abuse through medical treatment. Most disabled children are cared for by informed and loving parents who make treatment decisions in concert with concerned, capable health practitioners. Some of the extraordinary adversarial procedures established in the legislation and which are applicable to the majority population are reviewed below.

Subsection 3(2) of the bill makes applicable to children under age 16 provisions giving rights advisers—that is, advocates of a certain form—exceptional rights of entry. These rights of entry are excessive and inappropriate when applied to the majority population. The advocate's vague belief that a child wants his or her services is not an acceptable basis upon which to grant him or her the automatic right to enter a facility, a controlled-access residence or a private residence without a warrant, nor is it an acceptable basis upon which a warrant of entry should be issued by a justice of the peace.

Should a parent refuse the advocate entry to his home or otherwise deny him access to the child, the parent may be found guilty of an offence either under section 34 or for denying entry under a warrant. These penalties have absolutely no moral or logical justification when applied to the parent who believes he is acting in the very best interests of a child whom he loves.

ESPACE states that the advocates' rights of entry can only be warranted and justifiable in situations where there is a serious apprehension of child abuse through medical treatment and that accordingly these matters are best dealt with in legislation specifically designed to remedy cases of child abuse.

ESPACE states that when applied to disabled children under age 16, the proposed rights of entry are unwarranted and a direct erosion of the rights of citizens in our society to privacy and property.

ESPACE states that in the absence of child abuse the proposed rights of entry interfere with the parent's right to settle the question of medical treatment directly with his child. They will create a destructive, inflammatory situation where the child may be witness to coercion of a parent, possibly with the presence of the police.

Despite the enormous impact rights advisers will have on the lives of disabled children and their families, Bill 74 denies children representation on the Advocacy Commission. ESPACE repeats that children should be represented by those who care for them, know them best and are the secondary consumers of the legislation—namely, their parents.

Section 10 provides for the appointment of an advisory committee to include family members of vulnerable persons over age 16. ESPACE objects to this section as written for two reasons. The committee is not appointed by the Advocacy Commission but by the minister. If the commission is to be truly independent, as promised by this government, it must have full control over the appointment of those

from whom it seeks advice. Second, children under age 16 will again not be represented on the advisory committee.

Clause 7(1)(k.2) gives the Advocacy Commission the right to establish complaints procedures relating to advocates, but only with the approval of the Minister of Citizenship. ESPACE states that the commission should again be free and independent to address regulation of its advocates without the minister's involvement or veto.

In regard to Bill 109, pursuant to section 9 of Bill 109 the criteria standards procedures applied by a health practitioner in assessing capacity are still left to be determined by unknown regulations. This crucial and fundamental element of the act ought to be clearly set out in the draft legislation so that it is subject to public scrutiny. It should not be hidden from public knowledge and debate.

Similarly, section 10 leads to prescription by regulation of the complete list of health facilities and the full enumeration of controlled acts the existence of which will trigger a mandatory written notice to the child and notification of the rights adviser. The public and all interested parties are currently deprived of the opportunity to examine these matters which set the conditions for bringing an application before the Consent and Capacity Review Board.

Although section 10 ostensibly restricts the intervention of a rights adviser to children over age 12, subsection 10(13) empowers a child under age 12 to apply to the board to challenge a finding of incapacity. ESPACE repeats its strenuous objection to the application of adversarial procedures to all children under age 16 and most certainly the very young, under age 12.

ESPACE believes that the majority population would be best served by investigative and counselling procedures to reassure fearful children or to bridge gaps of understanding between the child on one hand and the parent and the health practitioner on the other. Applied to the majority population, the procedures now proposed will be destructive to the parent-child relationship and will severely impede treatment delivery to disabled children.

Pursuant to subsection 10(8), "The rights adviser's explanation is sufficient, even if the person does not understand it." Pursuant to subsection 31(1), a person is deemed to have the capacity to instruct counsel in a hearing before the board. It is remarkable and anomalous that a child who cannot understand the purpose or implications and consequences of applying to the board is presumed to be able to direct a lawyer in the conduct of proceedings before the board and before an appeal court. The disturbing reality is that an appointed lawyer who is a total stranger to the child and his circumstances will decide how to conduct the hearing and whether an appeal from the decision will be taken or defended.

ESPACE submits that no lawyer should be given such powers. I, ladies and gentlemen, professionally am myself a lawyer, and as a parent and as a lawyer I repeat that no lawyer should be given such powers. To do so is a step beyond the bounds of reason and common sense, particularly where the proceeding is brought to challenge the decision of a responsible, informed parent regarding the medical treatment of a child.



Pursuant to section 26, parties to a hearing before the board to review a finding of incapacity are the person, the health practitioner and any other person the board specifies. ESPAC strenuously objects to the exclusion of parents as automatic parties to the hearing. Parents of children under age 16 must have a clear, automatic and unequivocal right to be parties and consequently to have the right to present their evidence, make their submissions and test the position of the lawyer appointed to represent the child. The board ought to have no discretion whatsoever in this regard.

Parents, more than any other persons, have an interest in the outcome of the hearing and any appeals therefrom. They have a moral and legal obligation to do what is in the child's best interest. It is they and their children who must live with the impact of the decision. Anything short of a clearly stated right of a parent to be a party is absolutely unacceptable to ESPAC.

Under section 26, the health practitioner ought to have the status of a witness only and should not be made a party to the hearing before the board. The proposed section obliges the practitioner to take on the burden and the risk of litigation in a proceeding or multiple proceedings in which he or she has no direct personal interest. In addition, the bill is silent on who is to pay for legal counsel for the practitioner, leaving the untenable implication that he or she must retain counsel at his or her own expense.

1140

Pursuant to section 41, only a party to the hearing before the board may appeal the decision. If a parent is not appointed as a party, it appears that the health practitioner must decide whether an appeal should be taken or defended in a case in which he or she has no direct interest. Similarly, the question remains whether the practitioner is obliged to retain and pay for legal counsel to conduct an appeal.

In summary, ESPAC submits that the proposed amendments will not remedy the glaring inadequacies of Bills 74 and 109. Instead of assisting disabled children and their families in obtaining necessary health treatment and services, they will produce the opposite effect of imposing additional emotional, financial and practical difficulties on those already burdened to their limit.

**The Chair:** Thank you very much. First of all, a clarification.

**Mr Malkowski:** I just want to clarify in terms of access, and I'll refer that to the ministry person.

**Ms Mary Beth Valentine:** To refer to the concerns you've expressed about access and penalties, the due process requirements of rights advice, as required by other acts, are the only advocacy that refers to children under age 16 in Bill 74, so much of the concern you have expressed is basically irrelevant, to the extent that a child under the age of 16 will not have access to an advocate. The only requirement is if there is rights advice required in relation to the consent bill or the guardianship bill. My colleagues may wish to further address that.

The issues for penalties are clearly not in relation to private premises; they're for facilities in controlled-access residences.

**Mrs Donald:** With respect, if you look at sections 17 and 18, it is not at all clear to me in reading those sections that the penalties do not apply.

**Ms Valentine:** In section 34, it clearly states that it's related to controlled-access residences and facilities. I should clarify for you that I'm not counsel, so I'm not giving a legal opinion, but I'm giving you the interpretation.

**Mrs Donald:** I have a very difficult time reading those three sections together. I have come up with a number of interpretations, one of which, as anomalous as it may seem, is that penalties may apply if a family lives in an apartment and may not apply if they live in a private residence. That's one interpretation I come up with. Then there is a part of section 17 which incorporates section 18, and in my view—for what it's worth—I'm not at all clear that parents will be absolved from penalties if they do not allow a rights advocate entry into their premises.

**Ms Valentine:** I can assure you that is not the policy intent, but I will ask legislative counsel to review it again. We've been assured that is not what it says, but I will take your concerns back. I will assure you that is not the policy intent.

**Mrs Sullivan:** Once again, this last interchange has just pointed out the very issue we were discussing earlier today, and that relates to the absence of legal counsel for the Ministry of Citizenship and the absence of the minister herself. I really think that's inadequate.

This is a very good brief. I think at the beginning of your remarks you indicated that you didn't have a lot of resources in terms of preparation and analysis, but you've done an awfully good job here.

One of the areas we're going to request further clarification on from Health counsel, if they're ever around, relates to subsection 10(13) and the issue you've raised indicating that this section does empower a child under 12 to apply to the board to challenge the determination of incapacity. We would also like clarification and a further discussion with the committee with respect to the section relating to standing before the Consent and Capacity Review Board, which I think you've discussed very well in this document.

We've certainly had representation from health care practitioners with respect to questions associated with their being included as having standing before that board. Dentists raised it yesterday. Are they going to have to leave their practices, by example, to appear before the board, and is that an obligated duty? Other groups and organizations have also raised the issue of the standing of parents, and the children's aid societies have raised that issue as well. We'd like to have further discussion with counsel and, frankly, with the minister with respect to that issue.

This is a very good brief and we'll follow up further along. I don't have any further questions because I think what we need now, frankly, is some responses.

**Mr Jim Wilson:** Thank you, Ms Donald, for what I also think is a very excellent brief.

I think the government's splitting hairs on whether, when you're under age 16 or 12 and above, you have automatic access to a rights adviser if need be, but you



don't necessarily get an advocate. In the first round of the original draft of this legislation we had advocates in all legislation, and then Bill 109 was changed to the rights advisers. Now we're told that if someone has a rights adviser and asks for something that may require advocacy, the rights adviser has to stop and say: "No, I'm not an advocate. Wait. I'll get you an advocate." So we have two people showing up at one location to do what was one person's job before.

I don't think you're off base at all, and I think the response from the bureaucrats and from the government is really playing around with words. It may be clear in the government's mind about the difference between a rights adviser and an advocate, but it's certainly not clear in my mind, and I'm almost positive it won't be clear in the minds of most consumers after this legislation is passed.

I did want to ask you one sweeping question. Would you say, as a general rule, that the government should just butt out of people's lives who are under age 16?

**Mrs Donald:** As a sweeping statement, I would say yes, with this caveat: that we at ESPAC also see a need to protect young children under 16 who will suffer abuse through medical treatment.

But what has happened with this legislation, in the government's, I suppose, intense desire and perhaps haste to protect this minority, is that it's cast an enormous net and it's catching ordinary citizens—to use the vernacular—where it has no business being and it will be interfering with parent-child relationships.

We at ESPAC are extremely protective of our children. The majority of parents are extremely protective of their children. They do not make medical treatment decisions lightly. For some of the treatment these children get, the decisions are made over periods of years and involve a course of conduct and a course of treatment, as opposed to one isolated treatment.

It seems to me that this legislation is inappropriate to those. We do not say this legislation is totally inappropriate to everyone. That is not our function or our purpose in being here. We are saying, please do butt out of the normal family situation of the parent and the disabled child.

**Mr Jim Wilson:** You describe in your brief the normal family situation. You call that the majority.

**Mrs Donald:** I do.

**Mr Jim Wilson:** Given the legislation as presented and before us today, do you have any specific thoughts on how we can fine-tune it so that it really does address the need of the minority or the few children who may need protection?

**Mrs Donald:** I suppose my sweeping recommendation is that if any legislation has to be amended to include abuse through medical treatment, it would probably be the Child and Family Services Act. That's where this matter can be addressed without touching everyone else.

The other thing I think should be done is to provide systemic advocacy for these children and for all children. We had hoped that would happen under Bill 74. If systemic advocacy is undertaken, then maybe what will happen is that we will be able to streamline the service delivery and

we will be able to find where abuse and abusive situations are likely to crop up. If that sort of advocacy is undertaken, then over a period of time I think you will be able to better identify where, in the normal system, unhappy circumstances occur, even with the presence of a competent health practitioner and a loving parent.

**Mr Jim Wilson:** Thank you. That's very helpful.

1150

**Mr Sterling:** As you hear more and more about Bill 74 and the other acts, you begin to go back and you start to say, "Maybe I'm looking too much at the trees and not enough at the forest."

You would be familiar with a lot of family situations where there is tremendous pressure on the family because the children have significant disabilities. In your opinion, are there enough safety nets out there to make certain, either in a family or outside a family situation, that a child is not going to be maltreated?

**Mrs Donald:** I think that applies to all children, though. I don't think it applies any more to disabled children.

**Mr Sterling:** But I think there may be more pressures on the family because of the extra burden.

**Mrs Donald:** Well, let me put it this way. I don't think that is a factor to be considered in this particular legislation.

**Mr Sterling:** Okay, that's fair.

**Mrs Donald:** I can also say that where abuse—I gave an example the last time I was before this committee. Take, for example, the child who needs a number of different surgeries. I have a little boy who needed spinal surgery and eye surgery. This is a systemic problem. There is no case manager in the medical community to do this; you end up being a case manager yourself. So you're sent off to the ophthalmologist; you're sent off to the neurosurgeon.

What if the neurosurgeon said, "This month we're going to do the spinal surgery," and goes ahead and books it and we've all agreed it was going to happen, and then for some reason the ophthalmologist says, "We're going to have some eye surgery scheduled three months down the road." The fact is that spinal surgery takes three or four months to recuperate from; it's an extraordinarily demanding and painful procedure. Being the parent of a child, I would never, ever allow those surgeries, for example, to be spaced in such a short time.

But I can see where, for example, a parent who maybe has difficulty with the language or thinks that doctors know best or assumes that doctors always speak to each other goes ahead and has this surgery scheduled within, let's say, three months of each other. That, I would say, is an abusive situation. It is not intentional, but it might occur.

So even in this situation, say the child is vehemently saying no and indeed wants to speak to somebody about this, our suggestion is that in circumstances of this kind, the best way to deal with it is not to get a Consent and Capacity Review Board hearing going, with rights advisers and then you suddenly have a lawyer appear on the scene and so forth, but rather perhaps a better consultative, investigative and counselling procedure. If then you find that you have a parent who, having gone through that procedure,



still insists on subjecting this child to that sort of treatment, then surely the law should protect that child. I personally don't have a problem with it, and I know my committee doesn't have a problem with that.

What we object to is that willy-nilly, without going into any details of the situation, you have a fearful child—and all children are fearful of surgery, some more than others. Some will express it; some won't. Parents, for example, and doctors spend an awful lot of time preparing a child psychologically for surgery, but it happens. But to willy-nilly thrust these people into an adversarial situation I think is absolutely untenable.

Not only that, but you have to remember that some people bring their children for surgery to the Sick Children's, for example, from other parts of the province and from other provinces. So you've gone through the rigmarole of preparing the child and preparing yourself; people often have to make arrangements for the rest of their family to be cared for. One parent comes to Toronto and suddenly, after all that, finds himself in a situation where he is not only not getting the surgery done but also has to go through a Consent and Capacity Review Board hearing and maybe an appeal.

May I just add to this that I know for a fact that appeals are not easily obtainable in Toronto. You have to wait three to four weeks to get your motion on for appeal, so this is not a quick procedure here.

**Mr Sterling:** You're saying the Advocacy Commission would be best suited in your instance to do systemic advocacy for children under 16, but otherwise it should stay out of the lives of—

**Mrs Donald:** For the majority of the population, yes.

**Ms Akande:** Thank you very much. I'm sure you're tired of hearing it, but it is an excellent brief, and I do appreciate the narrative way in which it's written because it gives me an opportunity to also express that I am not a lawyer.

I am interested, though, and always am, in, what is there in Bill 74 which encourages you to believe that the intent of the legislation, or in fact the way it's written, will allow physicians or encourage them to assume that a child's aversion to pain and reluctance to endure it—which is very common; you're quite right—will be interpreted as his or her withdrawing consent for the procedure?

**Mrs Donald:** I don't understand your question.

**Ms Akande:** What is there in the way the legislation is written that encourages you, or the group, to believe that the child's aversion to pain—you've drawn this analogy of a parent bringing a child to Toronto and preparing him, and of course all children, it doesn't matter, you know, are not going to be anxious, but they've been prepared, and when they're confronted with the real thing they will not necessarily be joyous at the prospect of having this painful procedure. What in this allows you to believe that will be interpreted by the physician as a withdrawing of consent where they'd have to bring in a rights adviser etc?

**Mrs Donald:** As I understand it, if there's a finding of incapacity in any case, and given the limits imposed by those sections dealing with certain types of facilities and

controlled acts, the physician will have to give notice to the child of his or her right to speak to a rights adviser. I think I'm right on that.

If that's the case, then I can see a situation where, let's say, a child is very fearful and suddenly the child is told, "I don't think you're capable of making this decision, but you do have a right to speak to a rights adviser." That child then suddenly says to himself: "I've been told by my doctor, by my Mommy, by my Daddy for all these months that I have to have this surgery. Now wait a minute; maybe I don't." The child first of all starts to question the advice and the things his parents have been telling him. I think it erodes some trust right away. It says: "Maybe somebody knows more than my Mommy or Daddy and knows much more than this doctor. I'm going to speak to this person who is the rights adviser."

Does that answer your question?

**Ms Akande:** It does, and what I was looking for is where exactly it gave that impression, because certainly it's not our intention that this would happen or that the decision of the parent would be eroded, but I'm understanding in general what your response is. I don't find it in the legislation, but I'm going to look back at it and see, because that is certainly not our intent.

1200

**Mrs Donald:** I think section 10, the way it's written now, certainly includes that interpretation, my interpretation, of what is to happen, and what is to happen is that given a certain set of circumstances in a certain facility dealing with certain treatment—I might point out here that certain of the treatments are also to be dealt with by regulation, so in part I don't even know what I'm talking about right now. But given a certain set of circumstances, some of which is unknown because it's to be dealt with by regulation, once the child is found incapable, a child can indeed make clear to a physician that he or she wants to speak to a rights adviser. That is all that is really necessary to get the whole process going.

That child may retract, obviously. There's a section in section 10 that says that if the rights adviser comes along and the child no longer wants to speak to the rights adviser, then of course the process is at an end.

But I would think that a frightened, fairly intelligent 12-year-old, getting wind of the fact that maybe he or she doesn't have to go through this, that maybe Mommy and Daddy are wrong, very well might proceed and ask for a lawyer, once it's suggested to him, or a lawyer can be automatically appointed, and then it's out of the hands of the parents, it's out of the hands of everybody; it's squarely in the hands of a lawyer.

**Ms Akande:** There is a point of difference—

**The Chair:** Thank you.

**Ms Akande:** —we cannot pursue now because I'm being cut off in time, but I'd like to speak to you after about it.

**The Chair:** Ms Donald, on behalf of this committee, I'd like to thank you for taking the time out this morning and giving us your presentation.



CANADIAN ASSOCIATION  
FOR COMMUNITY LIVING

**The Chair:** I'd like to call forward our next presenters, from the Canadian Association for Community Living. Good morning. You'll be allowed up to half an hour for your presentation. The committee would appreciate it if you'd keep your comments short to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Ms Diane Richler:** My name is Diane Richler. I'm the executive vice-president of the Canadian Association for Community Living. With me today is Kenneth Pike.

I'm sorry, Mr Chairperson, I wonder if I could start with a point of clarification. I had been led to believe that because of a letter that had been forwarded from the Ontario Association for Community Living, which had a shorter time period, we might be allowed a few extra minutes today in order to cover some of the points that hadn't been able to be covered when they were cut short.

**The Chair:** I discussed this earlier and I said I would allow some flexibility, yes.

**Ms Richler:** Thank you. I want to thank you for giving us the opportunity to appear before you a second time, and we have tried to do considerably more work in order to have quite different comments today.

Before starting, I'd like to acknowledge the presence in the room today of the new Ombudsman of British Columbia, Dulcie McCallum, who is here as an observer today. You may remember that the last time I appeared representing CACL, Dulcie appeared as a member of our task force on alternatives to guardianship. Since that time, on August 4, she was appointed Ombudsman of British Columbia. We've been having a bit of bad luck with our task force, because she's the second member we've lost, the first one being David Vickers, who was a lawyer who was appointed a justice of the Supreme Court of British Columbia. I've warned Ken that he should be expecting something to happen to him after his appearance here today.

I'd also like to mention that since our last presentation, a more formal coalition has been developing between the Ontario Association for Community Living, which is a member organization of CACL, People First of Ontario and People First of Canada. We have some cross-appointments in our work on this matter. Audrey Cole, who appeared here representing OACL, also chairs CACL's task force on alternatives to guardianship. We have with us in the room today representatives from OACL, People First of Ontario and national People First as well as CACL.

We understand that the point of view we are presenting today, and the point of view of our coalition, is somewhat out of sync with many of the other advocacy groups that have appeared before you.

The first point I would like to make this morning is how CACL, as an organization that was founded in the interests of people who had been labelled mentally handicapped, really had to learn the hard way to listen to those people who have been labelled and to hear what they had to say.

The very first matter self-advocates raised with our association after their first representative was elected to our board of directors was in a matter of sterilization, which ended up being decided in the Supreme Court of Canada as the case of Eve. In that situation, we had been approached by the public trustee of Prince Edward Island to see if as an association we wanted to intervene in a question of sterilization. Our board of directors, while it claimed to represent people who had been labelled, was unable to make a decision because parents felt they should still have some say over the future of their sons and daughters. The self-advocates who were present said that no one, but the individual should be able to decide questions of sterilization.

To make a long story short, the ultimate unanimous Supreme Court decision was in favour of the position of the self-advocates, so the law in Canada now is that where a person wants to consent to his or her own sterilization, that's fine. Where they cannot give informed consent, then no one else—no parent, no friend, no court—can give that substitute decision for them.

I would ask everyone here who's a member of the committee who has at one point or another found themselves as a member of a devalued group, whether because of gender, colour, religion or disability, to remember what it feels like to be told you just don't understand the point of view of the greater group, and to understand how it feels to People First members and to members of our association who are being told they just don't understand the point of the current legislation.

I'd also like to point out that we've found ourselves at many times in difficult situations where we've had to choose between being true to a larger coalition or representing our own self-interest. A most recent example came about when we were trying to have the Alberta human rights code amended to include prohibition on the basis of mental disability, and at the same time there was a move to include prohibition on the basis of discrimination because of sexual orientation.

At one point it seemed as if the government might be willing to go with mental disability but not with sexual orientation, and what was put to our group was, were we willing to break from the coalition in order to get what we wanted? Happily, we did not break and the human rights act was changed in Alberta to afford protection to all disadvantaged groups. I'm afraid that from our point of view, that's the choice other advocacy groups in Ontario are going to have to make now, whether to fight for the greater good or to focus on their own self-interest and take what they can get now.

In terms of the specifics of our proposal, we have tried to look at the particular amendments you've put forward. We understand that careful consideration was given to many of the points we made last time, and we have gone back and taken our position considerably further.

I'd like to turn to Ken Pike and ask him to make some detailed comments on our brief, and then I would like to just make a couple of closing comments. I'll mention that Ken is a lawyer. He is from New Brunswick, where he is project coordinator of the older parents project of the



Fundy regional council of the New Brunswick Association for Community Living.

This is a three-year project, funded by the Donner Canadian Foundation and the Department of National Health and Welfare, which was established by older parents who were starting to ask the question about what the future would be for their sons and daughters when the parents would no longer be there to protect them. Ken also has a brother who's been labelled mentally handicapped, so he's here in his dual capacity as a family member, as a lawyer and as a member of our task force on alternatives to guardianship. Ken, I'll turn it over to you.

1210

**Mr Kenneth Pike:** We appreciate that what is before you today in our submission is lengthy and detailed and that you haven't had time to read it yet. We'll try to summarize it as best we can today. At the back of your document there is a diagram, which I'll be referring to in a few moments, which tries to capture what we're talking about. Our submission represents the development of thinking of our association and particularly the members of the task force on alternatives to guardianship.

We have long held the position philosophically that there is fundamentally something wrong with guardianship. Up until this time, however, we have not been able to offer anything as an alternative. We feel at this point, though, that although our document and our task force mandate have not been completed, we are well on the way to providing something that we consider to be a positive alternative to guardianship. I would add the disclaimer that some of these issues are still under discussion by our task force and that the contents of the document may change somewhat when the final report is delivered in October.

It's important to come back to the description of traditional guardianship legislation, which Bill 108 certainly falls under, as a necessary evil. Our question is, if that's the best description we can give to guardianship legislation, isn't it incumbent upon us to find a different way?

That traditional kind of guardianship is based on certain assumptions that we reject, those assumptions being that self-determination and autonomy are valid if people are able to exercise those rights independently, that some people are of lesser value than others and that some people are incapable of expressing wishes and choices.

The consequences of those assumptions on which guardianship laws are built are that people are assessed and categorized on the basis of their perceived inability to perform to prescribed standards; people lose their legal and social status as individuals within the broader community. Guardianship exacerbates disability. People with disabilities are already discriminated against and face the double jeopardy that social and legal processes will strip them of their rights completely.

Who benefits from this? We don't think anybody benefits from this, except perhaps in the short term maybe third parties who require an authorized, legally recognized decision-maker to justify their actions. But I think it's important to remember that everyone in this room today can end up within this process, whether because of illness,

injury or old age, and we should ask ourselves, would we rather be assessed and replaced or would we prefer that society take a more human approach that would support us and enable us to participate?

What we are proposing in our submission today is what we call a new paradigm for decision-making. It is a new paradigm because it's a different conceptual framework which rejects the assumptions and the framework of the old paradigm. In our view, the new paradigm accepts that every individual is a person of value, that each person has a will and an ability to express desires and that decision-making is often a communal and interdependent process, not simply an independent process. This new paradigm obliges us to listen to people who have heretofore been excluded from participating in matters that affect their own lives. We must overcome our limitations as a society to listen to people.

On pages 4 and 5 of our brief, we mention some of the other principles on which this new paradigm is based, recognizing that people require personal support when making choices and decisions. Support may involve providing advice or information, discussing options and consequences, communicating an individual's wishes or decisions to third parties or interpreting the will of an individual, but all forms of personal support shall empower the individual and give effect to his or her wishes and desires and be free from conflicts of interest.

People are interdependent and the law must respect and recognize this and give status and validation to decisions which are made with the support, affection and assistance of others. The cornerstone of what we are calling supported decision-making is the existence of a trusting relationship between the person receiving support and the person giving support. Where the person is isolated from his or her community, for whatever reason, there is an obligation on the state to provide whatever resources are necessary to reconnect or connect that person within the broader community.

Also, the law must not discriminate on the basis of perceptions of a person's capacity and competence. All law must be consistent with the values, principles and provisions of the Canadian Charter of Rights and Freedoms. The interests and concerns of third parties must not lead to an infringement of a person's right to make choices. Such interests and concerns must be dealt with in ways which are consistent with these principles. Lastly, no individual should be assessed to determine his or her competency or capacity. We feel that the only things that should be reviewable are individual decisions.

To bring this new paradigm of supported decision-making into being, we have to look at a new form of legislation, what we are calling enabling legislation. We need laws that will enhance rights and participation, not take that away. Laws must reflect an ethic of compassion, understanding and interdependence, recognizing that enabling legislation for people with intellectual disabilities will be the ramp that building codes and access laws are for people with physical disabilities.

The laws that have been designed to overcome disadvantage, whether we call them enabling legislation or equitable



legislation, are not new. There are various forms of legislation currently in this province—pay equity, employment equity and duties to accommodate within human rights legislation—that are also designed to overcome disadvantage.

Within the context of supported decision-making, we feel that enabling legislation should have some basic characteristics. A statement of intent or purpose would be contained in a preamble, as well as the principles that we referred to earlier. There must be a validation and recognition of supported decision-making as a legitimate means of making decisions, and there must be an explanation of supported decision-making, including provisions which establish how those providing support will be legally recognized.

The legislation should set some general parameters for supported decision-making, as well as outline some duties, obligations and procedural ground rules for those providing support. There must be other enabling provisions within the legislation that would overcome specific existing barriers to decision-making and participation, and we will refer to those in a minute. There must be provision for state-funded mechanisms to connect people who are isolated from their communities and facilitate informal networks of support.

The legislation must also provide a positive duty on the state to maximize the availability of communication mechanisms. It must also outline how decisions will be made by people who desire or require support but who have no one to assist them, and it also must provide measures for safeguards in accountability for the process itself, as well as forms of adult protection.

All of this legislation should also be supplemented by what we call a statutory audit and omnibus legislation which would bring other forms and pieces of legislation in line with the enabling legislation for supported decision-making.

I will briefly make a few comments on how we envision this new enabling legislation will work. If you would refer to the diagram at the back of your submissions, it is important to make note that the individual concerned is at the centre of the circle; it is our opinion that in a guardianship model, the guardian would be at the centre of the circle and the individual would be somewhere on the periphery. Around that person is his or her informal support network: family, friends, neighbours and people with whom he or she is in contact. What the legislation must do is give some recognition to that informal network so that the decision-making which occurs within that interdependent process becomes valid in the eyes of the law.

1220

We are suggesting three ways by which people can be recognized under enabling legislation: first, by designating in writing whom the person would want to have as his support persons, which is more of a traditional type of recognition; second, by indicating a desire through non-traditional forms of communication which are documented and validated by independent witnesses; third, and important, by recognizing the existence of trusting relationships between people, which may be particularly important for people who have very limited communication abilities but do have, as we feel all people have, the capacity to trust

others. So we recognize those trusting relationships as a valid way of making interdependent decisions. We feel this kind of process would be inclusive and not exclusive.

Once the support network is recognized under the legislation, the network will be obliged to perform to certain standards of conduct. Those standards are mentioned on pages 8 and 9 of our brief. They are basically designed to ensure that those people who provide support make all reasonable attempts to find out the desires, wishes and choices of the person receiving support. Supporters will be obliged to use all available aids to communication, respect the individual's wishes as to how much and when support will be provided, remember at all times that the role of the supporter is not the substitute decision-maker, not benefit from the position and be free from conflict of interest.

In the diagram, on the circle beyond the "recognized support system" circle are various kinds of decisions which the interdependent process will be involved in: financial property, economic participation, medical and personal care. We envision that there will be a need in some circumstances for some procedural ground rules to safeguard and validate those decisions in the process. Those kinds of ground rules may involve the preparation and signing of declarations on the part of support people.

We also feel there may be a need to build into the process some limitations on the kinds of decisions which can be made, in particular those where the risk of misinterpreting the wishes and desires of the individual would cause great harm or disadvantage, such as in the cases of sterilization and organ transplants.

An example of how this system would work is provided in our submission in two circumstances: in particular, the entering into contracts by individuals, and the informed consent for medical decisions.

Under the contract situation, which is significant from the point of view of economic and social participation where the law presently provides a barrier because of requirements around being able to understand the terms and conditions of the contract, we don't propose that we throw out the old law of contracts. We are proposing that it be modified to enable individuals to make decisions with the support of others. So in that circumstance, in regard to the person and his or her support network, the terms and conditions of the agreement would be understandable within that network, but that contract would be seen to be the contract of the individual and not the support network. The only case where the individuals providing support would be liable under the contract would be where there would be fraud or misrepresentation on their part. We are suggesting the same kind of process for medical decisions as well.

An important part of this model is what we're calling the checks and balances, the safeguards. The built-in safeguards will be the standards that will be imposed on people providing support, the limitations and the kinds of decisions possible and some public education on what supported decision-making is and how different it is from substitute decision-making.

We are also proposing some kind of external review process which does not assess the individual but is there to hear challenges to specific decisions or people who may be



providing support. That review process may also be able to mediate conflicts. We also envision the need for adult protection legislation which will balance the need for protection against the rights of the individual to take risk.

That is a very brief and concise review of the model. Diane Richler would like to make some closing remarks and then we would be prepared to attempt to answer your questions.

**Ms Richler:** One point that I'd like to make before concluding is just to inform you that at our presentation we raised some concerns that arose out of the report of the Royal Commission on Electoral Reform, which we thought might suggest that people in Ontario who are under some kind of guardianship order would be denied the right to vote.

I'm pleased to report that because our interests were raised with the Secretary of State, who was in the process of drafting omnibus legislation, a change has been made to the Elections Act that clearly states that all Canadians have the right to vote, regardless of disability, and there's no longer any opportunity for discrimination on the basis of disability. I just wanted to make sure that you have been brought up to date on that.

In closing though, I submit to you that I certainly understand that the detailed proposal we have come with today is quite radically different from the models that are proposed in the legislation you have had under review. I would ask that you consider them with the same seriousness that you've considered other suggestions throughout this whole review process and hope that despite the momentum that's behind the current proposed legislation you consider what the implications might be of implementing our approach.

If you feel that you're too committed and it's impossible to completely stop the process, we would ask that you at least consider a pilot project or a demonstration of the kind of model that we've proposed, similar to the kinds of diversion programs that the criminal justice system has put into place, so that you test the ideas and compare them with the more traditional models that are being proposed.

Further, regardless of whether you are able to support our model completely or whether you are able to recommend a more limited application of it, or even if unfortunately you decide to go ahead with the proposals that are now before you, we would ask that you build into all of the legislation before you a requirement for a statutory review within three years in order to assess the implications of the new system that's put into place, whatever it may be.

We've had experience at the federal level with a similar statutory review having been built into the Canada Evidence Act, and that's providing a wonderful opportunity for research on the changes to the act and what the implications are, certainly for people with a disability, and we ask that such a review be done in a way that would have the kind of detailed research that would be necessary to really evaluate whatever new program is put into place.

I'd like to just make one comment about the fact that because of the potential danger of guardianship that we've identified, we've certainly put the emphasis of our proposals to you on that aspect of the legislation before you rather

than on the advocacy legislation. I would just like to reiterate our concern with the advocacy legislation. We certainly recognize the need to empower individuals, their personal support groups and their organizations, but we firmly believe that it's not necessary to set up alternative structures and are particularly concerned with the potential of the lion's share of disability money going to the Advocacy Commission rather than trying to fix the problems that we're aware of in terms of the number of people in institutions, poverty and exclusion from schools.

My last comment is just to let you know that we've been approached by the Deputy Minister of Justice in the Yukon, alerting us to the fact that one of the legislative initiatives for the spring session is to prepare legislation around supported decision-making and indicating her intention to contract, in collaboration with CACL, to develop that legislation.

We fully believe that the government of British Columbia, in the selection of its new Ombudsman and given the review that's going on of its guardianship legislation right now, will be moving in the direction of supported decision-making and we hope that Ontario will not entrench an outdated model that will put it behind other jurisdictions in Canada instead of ahead.

1230

**The Chair:** Thank you very much. Questions and comments?

**Mrs Sullivan:** This is an interesting presentation and follows on the interventions that we have had before the committee from the Ontario Association for Community Living, as well as your own. I'm interested, in glancing through your brief, that one of the cautions that you put forward is that there should not be an overformalization of a system that would provide supported decision-making and yet, as I look through the brief, including some of the obligations that you've outlined for the supported decision-maker, some of the barriers in terms of contractual relationships for the supported decision-maker—mind you, I may not have hit it—you didn't address the question of tort liability and so on. The issues that you raise in terms of consent to medical treatment, it seems to me we're going to require a very formal approach, as we've discovered through, by example, the Consent to Treatment Act, which is supposedly simply codifying existing common law and ends up presenting a very formalized approach. I'd like you to comment on that.

The second area that I'd like you to comment on is that it seems to me that what you're saying is that for people who are now classified as incapable or who would be classified as incapable under the Consent to Treatment Act what you're really asking for is a system of almost consultation that exists for the person who is now classified as capable. I assume then that means that you in fact want no assessment of capability, and I wonder then what your views of the work of the Weisstub report and training the assessors and so on is.

**Mr Pike:** To address your first comment on the overformalization, one of the things that we were extremely wary of when we were meeting over the past few months



within our task force was the need to design legislation which would maximize and allow participation on behalf of people. We were faced with the problem that the laws, as they exist today, are barriers to participation; not only that, but the practice within our social service systems as well. We had to try and find a way of turning that around, almost of trying to flip things upside down, and that is going to require some modifications to existing law, things that we don't consider drastic, but modifications that will accommodate people.

There is going to be a need, we feel, to educate the public and people who will be involved in this process on what supported decision-making is all about and how it differs from substitute decision-making in order to allow people to participate and to recognize and validate decisions in an interdependent process, which really doesn't happen in any legal way right now. We are faced with the problem of having to build in some kind of mechanisms which would allow for that.

One of the things we did reject within our discussions was the need to register these support networks with a government authority. We felt that if we could build into legislation ways in which those people could be recognized as part of an interdependent process of decision-making around an individual, without registration, that would make the process less formal.

There are going to be some ground rules needed around all this because it's going to be new and challenging for people, and they're going to have to recognize that there will need to be obligations that people in positions of support will have to follow. There will be a need for checks and balances within the system to make sure that it is working for the benefit of the individual. We're not particularly concerned with that. We would be concerned if the process were so bogged down in legalese that it would be unworkable.

With respect to your second comment on the system of consultation, I guess all I can say on the purpose of this proposed model is that it's designed for participation, and it is designed around an individual, designed to maximize our ability, as people who support others, to listen to those people. I think if you look at the history of people with disabilities, many of whom have been considered to be incapable in the past—in fact we're not incapable—the problem was our problem, that we couldn't listen to people, we didn't have ways to communicate with people. That's what we're trying to do, build a model around people that will allow them to participate.

**Mr Jim Wilson:** Thank you for your presentation. I think this is the fourth time I've had the opportunity to hear an oral presentation of the new paradigm, better developed today than I've ever had it explained, and I like it. Every time I hear about it now, I get closer to understanding what you mean, and I think it really is the cutting edge.

Having said that, I have two brief comments. First, it's precisely our argument that ministers should be here to hear this type of innovative thinking. It's going to be extremely difficult for opposition members to be helpful because our mandate is rather closed in terms of addressing this particular legislation. My question there would be,

how have you been received in the past? Have you had access to the government side to explain the new model? Second, would your preference be that we just take a break now in these proceedings and take time out to consider the new paradigm?

**Ms Richler:** If I could answer that, I appreciate your suggestion. We recognize that we did not have our position this well developed until this point and were not able to bring it forward earlier. I also mentioned that we have a new coalition that's just developed, more formalized. The coalition has expressed an interest, and I believe there has been some openness on the part of the minister's office to arrange an opportunity for us to present these ideas to her. We certainly would appreciate that opportunity.

Regarding your point about the cutting-edge nature of this, the fact that it hasn't all been well explored, we would be more than happy, as a coalition, to put these ideas out in a more public forum and to allow people an opportunity to look at where the holes are and to figure out together how we can plug them. Our interest is not in putting forward a model that won't work; we want to collaborate with people to develop a model that will work, but will work in the interests of people.

In terms of stopping the proceedings, in our recommendations we gave a number of options. Ultimately, we would like you to do whatever would be possible to seriously look at this as an option to the more traditional model that's before the committee. If that's not possible, we hope that at least there will be enough resources put into this that a pilot or a demonstration could be developed in the province so it could be looked at with the kind of seriousness it deserves and not simply dismissed and buried after whatever legislation is passed.

1240

**Mr Winninger:** I certainly appreciated the perspective that you put forward. I remember when we had discussions earlier in the year, I raised my concern about the fact that guardianship may be a necessary evil, that there are situations—I gave the example of a person in a coma who doesn't have supportive friends or relatives there—where most logical people would say, "Maybe that's an instance where a guardian should be appointed."

I would submit to you that our thrust is not to displace the vulnerable person from the centre of the paradigm, and I think some of the amendments we've introduced go a long way towards ensuring that the vulnerable person does remain at the centre. For example, section 47.1 lowers the threshold level for capacity for a person to name an attorney for personal care, that is, where the person has the ability to understand that the proposed attorney has a genuine concern for the person's welfare and appreciates that he or she may need an attorney for personal care. That certainly confers the kind of autonomy on the vulnerable person that I know most people in the room will want to see retained.

Also, I point to section 63, which itemizes the duties of guardians of the person and attorneys for personal care. As I go down that list, I'm struck by the fact that the vulnerable person does remain front and centre here, because the



guardian has an onus to determine the wishes or instructions of the vulnerable person, to use reasonable diligence, to give more than lipservice to the wishes or instructions of the vulnerable person and also to consult with the supportive circle of family and friends to ensure that the actions taken by the guardian approximate as closely as possible the decision that the vulnerable person would make if he or she retained the capacity and competence to do so.

It may not be exactly what you envisage—and time does not permit me to deal with some of the ramifications of what you envisage—but I certainly suggest to you that the objective of this legislation is not to suppress the wishes and desires of the vulnerable person but to enhance them, either through the attorney for personal care, if that's possible, or to ensure that a guardian adheres to the wishes expressed by the vulnerable person or communicated through the family and friends.

**Mr Pike:** If I can just state a quick response to your comments, in relation to section 47.1, it's important to keep in mind that all the discussion around powers of attorney for personal care is still a substitute decision-making process, even though the threshold or test has been lowered in those circumstances to allow more people to enter into those arrangements.

What we're talking about is not the substitute process but a supportive process, and they are conceptually fundamentally different. I appreciate your comments around the legislation and how it tries to place an onus on guardians to consider the wishes of the individual and to consult with that person's close personal network, but what we're saying is that we don't need guardianship for that. Guardianship still is a process whereby somebody replaces the individual. The language is very clear: "decisions on behalf of." We're saying that decision-making is with and involving the person in terms of participation and determining his or her wishes with his or her personal support network. It's conceptually two different things we're talking about here.

**Ms Richler:** If I could just make one comment, I know Mr Malkowski attended at least part of Independence '92, which was an international conference on the autonomy of people with disabilities. I'm not sure if any other members of the committee participated in that conference. One of the things that struck me in meeting people from other countries and comparing the situation of citizens of Canada who happen to have a disability and people from other countries who happen to have a disability is that our Charter of Rights and Freedoms makes it very clear that people who have disabilities are citizens first.

My observation is that since the prohibition of discrimination on the basis of mental or physical disability took effect in 1985, there has been a gradual realignment of the perception by the Canadian public of persons who have a disability. There has been a gradual recognition of persons with disabilities as citizens: their right to vote, their entrenchment in the Constitution. Some of that presence in the charter has really enhanced the position.

Our concern is that by placing people under guardianship orders, no matter how well-meaning those guardians

are supposed to be and no matter how considerate—and probably most of them would be; we're not questioning their motives—it totally changes the position of the person in society, and it will mostly affect people with mental handicaps. It takes away their rights, strips them off little by little, and they'll no longer have the same image in society to have a right to work, to have a right to live where they want, to have a right to marry, to have a right to do whatever it may be. Their whole image is going to be of someone who needs protection and is in a different class from the rest of society.

That's what we're trying to protect ourselves from: once again going back to two classes of citizens where you either have a mental handicap or you're labelled to be mentally handicapped, or you're not. That's fundamentally our concern.

**The Chair:** Ms Richler and Mr Pike, on behalf of this committee I'd like to thank you for taking the time out and giving us your presentation today.

If we could, we will now go back to the discussion on Mrs Sullivan's motion.

**Mr Jim Wilson:** Very briefly, as I mentioned in my remarks to the previous presenters, it's an excellent reason why ministers should be compelled to attend these committee hearings. I did want, in my very brief moment, to read the letter from Howard Hampton, the Attorney General, to you, Mr Chairman, because I find it particularly disturbing.

"Thank you for your letter of August 10, 1992, requesting my appearance before the committee for the purpose of clause-by-clause consideration of Bills 108 and 110.

"Due to prior commitments I cannot attend on any of the suggested dates. Moreover, it seems unlikely that I will be available to appear before the committee at any time during the month of September."

I think the letter speaks for itself. It's unacceptable. It's the epitome of arrogance. I look forward to hearing the government members' response to Mrs Sullivan's motion, which we will be supporting.

**Mr Mark Morrow (Wentworth East):** I've been sitting here reflecting on Mrs Sullivan's motion for the last couple of hours. When she first brought it up, I wasn't going to support it. She'll be happy to note that I've since changed my mind, as long as the motion respects the time allocations as set out by the three House leaders in the House and as long as the motion also respects ministers' times. What I mean by that is that I do believe the three ministers involved will make every effort they possibly can to appear before us, understanding that their times are very limited. I would hope the motion would respect that. Again, just to reiterate, I will be supporting Mrs Sullivan's motion.

**The Chair:** Further discussion? Seeing no further discussion, all those in favour of Mrs Sullivan's motion? Opposed? Carried.

This committee now stands recessed until 1:30 this afternoon.

The committee recessed at 1250.



## AFTERNOON SITTING

The committee resumed at 1349.

CANADIAN DIABETES ASSOCIATION,  
ONTARIO DIVISION

**The Chair:** I'd like to call this meeting back to order. I'd like to call forward our first presenter, from the Canadian Diabetes Association, Ontario division. I apologize for the delay. We are running a little behind, so there are people taking extended lunches. Just as a reminder, you'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you would keep your remarks to about 15 minutes to allow questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Mr Peter Harvey:** My name is Peter Harvey. I am the chairperson of the social issues committee of the Canadian Diabetes Association, Ontario division. I'm also a member of the national advocacy council, which is one of four councils of the Canadian Diabetes Association.

I would like to thank the committee for the opportunity of reappearing to speak to the proposed amendments. In our original submission, made on February 13, 1992, we gave a history of the CDA, an overview of the nature of the disease diabetes and suggested some changes that the organization would like to see made to the act.

The CDA has a different approach to this act, as we expressed in that original submission, and that is that we look at the various goals set out in the act and the methods of achieving those goals. It is these that we look at for the various powers that might assist people with diabetes. In particular, we look at the sections which deal with changing social attitudes, political attitudes, institutions and so on.

The CDA is dedicated to effecting change for the betterment of people with diabetes, but rather than rehash the particulars of our original submission, I've prepared a very short summary of the two or three areas where we think we, as an organization, might have problems with the proposed amendments. In addressing those, I would just like to flesh out where we see these problems and why they arise.

The first is with respect to the definition of "vulnerable person." This goes to the very core of the act, but there we see that in the words we are probably limiting the applicability of this act to people with diabetes. The words "moderate to severe," for example, cause a lot of concern for us because we don't believe there is such a thing as a "moderate to severe" case of diabetes.

An individual is a person with diabetes. They have type 1 or type 2. The ravages of the disease that follow diabetes can be very severe, but those are usually dealt with separately. Heart disease, blindness and so on affect people with diabetes. In fact, diabetes is the leading cause of blindness in people. Diabetes is one of the leading causes of heart disease. But it is people with diabetes we are dealing with as a homogenous group, not people with diabetes who also happen to have other problems. Therefore, we don't know how we can define how this act is going to

affect people with moderate to severe cases or problems with diabetes, if that is going to be a linchpin.

The other problem is with the question of perception. If you were to ask a person with diabetes how he felt about his disease, whether he's discriminated against and so on, he'd probably tell you that he functions very well in society, but deep down we know there is systemic discrimination and we know there are problems. We know there are changes that must be made. For example, we know that going into the next century one of the biggest expenses this government is going to face is paying for health care costs for people with diabetes. The numbers are astounding. We put that in our original brief and I won't touch on it again.

We are suggesting that it might be helpful if the definition of "vulnerable person" were changed to incorporate the groups that are set out in subsection 15(1). In other words, if we found language such as, "Without limiting the generality of the foregoing, the definition of 'vulnerable person' shall include people within those groups referred to in subsection 15(1)," we would then be definitely caught within this act and we'd be able to act within it. There would be no doubt or question. But without that, we fear that while we are going to participate at the committee level, that's as far as we will be able to go.

We want to use this act to effect change. We want to use this act to affect community standards. Without being included in the definition, we're not going to have access to the very goals that this act sets out to achieve.

The other problem we see is with respect to subsection 7(2). This is a strange subsection to us because it authorizes a community agency to act on behalf of the commission in performing functions, and the functions that are set out, again, go to the core of the Canadian Diabetes Association's position on advocacy, education, health care and so on. Without being able to act as an arm of the commission, we feel that we are going to be restricted in our activities.

Now, this is a very difficult way to put this together, but if you take the cumulative effect of subsections 7(2), (3) and (4), you'll see how it excludes an agency such as the CDA. First of all, a "community agency" is defined as being "a non-profit community or agency that is authorized under subsection 7(2)." If you don't come within a definition of subsection 7(2), if you are not going to be a community agency within the act. A community agency within subsection 7(2) is one that does not provide services other than advocacy services.

The CDA prides itself on the fact that for years it has provided educational resources, health care resources, promotional resources for advising people as to the risks they are under. It sets standards in health care. It has set standards in devices and so on for the treatment of people with diabetes. It works within the health directorate of the Ontario Ministry of Health.

It is not within the purview of subsection 7(2). Accordingly, it cannot be a community agency. Accordingly, it can't get the funding, can't access the programs, can't provide the functions. We would dearly love to be able to access



this act to be able to do the rest of the things set out in subsection 7(1), such as providing additional advocacy services for changes, to develop community strategies, to educate people as to the problems that are faced with diabetes.

Subsection 7(3) allows grants to be made to community agencies, but we can't be a community agency.

Subsection 7(4) says, "The commission may authorize a person who works for the commission or a community agency" to do work for the commission. Again, we are restricted. We can't use our people in those programs.

We feel that subsection 7(2) should be changed to allow agencies that provide services other than advocacy services to fall within the definition. To give you a very clear example of what might happen, we feel that we may end up going head to head with other organizations and depleting very valuable resources, just because we provide services other than advocacy.

For example, ARCH, the Advocacy Resource Centre for the Handicapped, does some litigation, some procedural work for the CDA in the discrimination field. We've tapped their resources in the past. We now have our own resources that we use. But ARCH, theoretically, within the definition of 7(2), can carry out the functions that are there, which the CDA is geared up and set to do and is now presently doing. In such a situation, we're going head to head and we'll have competing programs. We're not sure the direction is going to be the best that can be achieved. There are very limited resources and we want to make sure these resources are used in the best way possible.

The last issue I want to address is one that was addressed in our previous submissions. I just want to reiterate it, and that is, that this act is geared towards empowering vulnerable people on a community basis. The loftier goals, though, of changing the systemic type of discrimination that this is geared towards alleviating, in part, is not a community goal, is not a provincial goal, is not a national goal; it's a global goal.

We've had the Year of the Disabled and it's now time to recognize that yes, there are mandates out there for organizations such as the CDA that are effective in operating within the provincial sphere as a whole. Because the CDA runs, through its branches at the grass-roots level, on a community basis, it should not be precluded from running that on a provincial basis.

Accordingly, the concept of community should be the community of people who are vulnerable, not communities on a geographical basis. We urge you to reconsider and to allow the commission to empower or to give grants to other than community agencies within a geographical basis, but on the basis of a larger community that is acting for the community of vulnerable people within this province.

Those are the submissions I'd like to make on behalf of the CDA. I think I'm a bit short of the 15 minutes, but I'm not going to extend it out. I know you've had a hard day.

1400

**Mr Jim Wilson:** Thank you for your presentation. We do appreciate the brevity of it, given that the CDA did give us a comprehensive brief in the first round.

With respect to subsection 7(2), it seems to me that advocacy means different things to different people and in fact is a very broadly used, broadly defined term. Would not the CDA, with perhaps slight modification of the wording of its mandate, be considered a community agency as per this act?

**Mr Harvey:** I don't believe so. If advocacy, in the meaning of the act, is to act on behalf of another person, to speak when the person cannot speak or formulate the ideas in a better fashion, in a comprehensive way, then that would necessarily have to exclude the setting of standards, for example, for blood glucose monitors.

Where we would interact with the Canadian Standards Association, for example, it would preclude us from probably dealing with some of the other issues of allocating research funds. That's one of our big goals: to make sure there isn't a lot of cross-duplication in the allocation of these funds. The CDA is very strong in that area, and traditionally it has been looked at as a research organization that funnels the funds into the proper hands. It's only recently that it's taken on this advocacy role, so I don't think it would be.

**Mr Jim Wilson:** Perhaps, Mr Chairman, I could ask a question through you to the parliamentary assistant. Was it the intention of the government to exclude the CDA from being contracted by the commission or receiving grants from the commission?

**Mr Malkowski:** I'd like to clarify. Our approach to this, of course, is to enable vulnerable people who have difficulty expressing themselves to have their expressed wishes known. That is the intent of the legislation, so I plan to ask questions, if I may, if I can get to that.

**Mr Winninger:** Mr Chair, could I add something as well in response to that? I'm just going by memory here, but if my memory serves me correctly there was some concern expressed that the same agencies providing services would be in conflict if they were also advocating. That's why the definition was narrowed.

**Mr Jim Wilson:** But would the type of advocacy the witness has described that the CDA does on behalf of its members not be considered, for example, systemic advocacy, when you're working with the CSA to help make regulations regarding standards, for instance?

**Mr Winninger:** It's an interesting issue. I was just recapitulating what my understanding was of that section and why it came to be.

**Mr Jim Wilson:** I think it's a point that we need to clarify, Mr Chairman. Perhaps the government could come back to us with a written response to my question.

**The Chair:** Okay. Anything further? Thank you, Mr Wilson. Mr Malkowski.

**Mr Malkowski:** Thank you for your good presentation.

Is there a consumer group affiliated with your organization? You also mentioned you have an affiliation with the Advocacy Resource Centre for the Handicapped, or have you used their resources? Could you talk a little bit more about that?



**Mr Harvey:** No, we have not what I would define as a consumer group as such. The structure of the CDA is basically a grass-roots organization that starts at the branch level that is then organized into a regional organization that then goes up into the Ontario division, reporting to the CDA national.

Each one of the branches is autonomous to a certain degree, and through them many branches run stores that will sell devices, insulin, syringes and so on to make sure that everybody has access to them at the least possible cost.

We have a provincial organization that provides an advocacy function. This function is often farmed out to private solicitors or to ARCH or other organizations that can assist us. We also have a national advocacy council that deals with issues on a national level. For example: discrimination, recently, in the armed forces is one issue, motor vehicle licensing, pilot licensing and so on. We don't have a true consumer group as such. It is a volunteer organization, primarily. We have no paid advocates.

**Mr Malkowski:** I will follow up the concern on the definition of a vulnerable person. If you're talking about terms, you were saying that doesn't include you, but we are trying to focus on moderate to severe disabilities. People have extreme problems expressing themselves. You're not satisfied with that term. Could you talk a little more about that?

**Mr Harvey:** That causes some concern, the first go-around, the definitional aspect. It's because of the use of the language in 15(1) that we feel we do have access to this act and the provisions of it.

"Moderate to severe" is a difficult issue, because a person who is in a hyperglycaemic reaction or a hypoglycaemic reaction, the opposite end of the scale, is certainly not able to speak for himself. That would be in the "very severe" range in anybody's definition, because in those circumstances the individual is usually incoherent or could be unconscious at the end of the scale.

We feel the act is well set up to protect the interests of those individuals. It is in the other areas dealing with the provision of what is referred to in 7(2), the functions, that it causes some concern. As vulnerable persons we are able to make sure that we can access the wider parameters of this act to carry out the goals dealing with systemic discrimination.

**Mr Malkowski:** I appreciate your concerns and certainly I'll raise your concerns.

**Mrs Sullivan:** These concerns which have been expressed by the diabetes association have also been placed before the committee by other organizations that are supportive in health care fields. By example, I think of the Arthritis Society, multiple sclerosis, heart and stroke.

Church groups have also indicated to me that they have some extreme difficulties in that they are providing advocacy services along with many other functions, including some of them providing or assisting in sponsorship of low-cost housing, for example, so that when other services or functions are being done by those associations, they are eliminated from the link with the Advocacy Commission

and cannot become an agent of the Advocacy Commission, if you like.

I think that while we do understand and while we have heard from certain groups that there is concern about a conflict of interest between the service provider and the advocate, we see many organizations across Ontario which are doing double duty as both systemic advocates and individual advocates and are providing individual advocacy and are also providing other services which are needed, where they may be the only deliverers of those services. We raise the issue not only because of the double duty but because of the difficulty in providing services on an equitable basis in every part of the province.

The government has not responded in any way other than to accept the argument that every service provider cannot be an advocate. We just feel that this is an inappropriate response and we're hoping that the Minister of Citizenship will respond to that. We believe there is an opportunity for a change of wording that would allow the health care organization and other groups that are providing services to participate.

We're waiting for change, but the minister, of course, doesn't come to the committee so she might not be hearing what's on our minds.

1410

**Mr Harvey:** I may respond to that by giving you a very positive example. We have been intimately involved with the Ministry of Transportation for the last three or four years to effect a change to allow people with diabetes to acquire other than a basic driver's licence.

On the advocacy level, the individuals being represented by a counsel who has, on occasion, been retained by the CDA and on occasion been retained by individuals, those were individual victories. It was not until the CDA was able to launch a concerted attack at the national conference dealing with motor vehicle registrars and licensing that we were able to effect a positive change.

That is one of the functions we would look at and say, "That is where the CDA should be working and exerting its weight and so on." We could change the individual's position by obtaining, on an individual basis, occasionally, a licence, but we couldn't change the discrimination that was built into the policy without going at it on a national level and then dealing with it on the provincial level. That's why we say that section 7(2) is very important to us. Those functions are extremely important.

**Mr Stephen Owens (Scarborough Centre):** I have a question either for the ministry staff or the parliamentary assistant for the Ministry of Citizenship. In terms of the concerns by the diabetes association, is it the view of the ministry that a diabetic would be precluded from the use of an advocate?

**Ms Valentine:** Not at all, and I apologize; I didn't hear the earlier discussion. As a matter of fact, diabetes is listed within one of the categories, in category 2 of subsection 15(1). Diabetes is specifically listed there. As I say, without hearing your earlier discussion, I can't clarify any further than that.



**Ms Akande:** I don't want to belabour a point, so my question will be brief. I'm interested in your desire to be included within the group that could provide advocacy services as well as providing other services.

There actually are two schools of thought around this—several, I should say. One is that adult protective service workers for one group have, for a long time, felt and said that they seemed at times to be in conflict with the very groups they were working for, the very agencies they were working for, when their ideas, views and recommendations about individuals differed from the agency's desire or views. Could you comment on that for me, please?

**Mr Harvey:** I can, because quite often we have to recognize that the rights of the individual or the desires of individuals often conflict with the betterment of the community as a whole. Again, if I can go back to my motor vehicle licensing problem, an individual feels he should have a licence to drive a bus, even though he is a person with diabetes. That may not necessarily be in the best interests of the CDA, because that individual may not have the responsibility or the ability to look after his disease and care for himself properly. He may be subject to hypoglycaemic reactions without knowing he's going to suffer them, yet the demand is, "I should have a motor vehicle licence to drive that bus."

The CDA itself lobbied for and wanted a change so that he would have the right to present his case to the motor vehicle registrar or licensing branch and let them determine, on known medical standards, what it is that he would have to do to obtain that licence.

**Ms Akande:** And the member of your agency who would be advocating on this person's behalf? His or her stance would be what?

**Mr Harvey:** We would probably not look after the individual. We would seek outside counsel for them.

**Ms Akande:** So in fact you're providing a different level of advocacy.

**Mr Harvey:** That's right.

**Ms Akande:** One that we expect all agencies will continue to provide: an informal level.

**Mr Harvey:** Yes. It is a formal level, though, because, for example, the motor vehicle licensing recognize the CMA's and the Ontario Medical Association's role in setting the medical standards. But again, those standards are set in conjunction with the CDA, so we are there on a formal basis at the same time. But we are performing the functions that are set out in section 7, other than the pure individual advocacy function. It's those ones that we are really keen about.

**The Chair:** Thank you, Ms Akande. One brief question, Mr Winner.

**Mr Winner:** I'd like to thank you for coming here today from London. A lot of people don't realize the connection between the discoverer of insulin and London and Banting.

**Ms Akande:** They do now.

**Mr Jim Wilson:** He's from my riding.

**Mr Winner:** It's significant that you have your head office on the edge of my riding. Depending on what side of the street it's on, it could be in it or might not be in it.

In any event, the question I want to put to you is in regard to your first recommendation, which would ask that section 2, the definition of "vulnerable person," be amended to incorporate, by reference, subsection 15(1). As I look at these sections in the reprinted text of the act, section 1 refers to individual persons and section 15 refers to organizations, so I just wondered where you were headed.

**Mr Harvey:** It would really have to be language-crafted to incorporate, by reference, individuals within the groups set out in subsection 15(1). It would then come back to the individual, but it would incorporate, by reference, the group of individuals with diabetes and so on.

**Mr Winner:** But, for example, people with a mild form of age-related diabetes that they control through their diet wouldn't constitute vulnerable people. Many people might ask, "Why are you allocating resources to people at the very mild range of diabetes who aren't vulnerable?"

**Mr Harvey:** I understand that. The issue there is, when does that person become a "vulnerable person" in terms of the definitional aspect? Do they have to suffer from hypoglycaemic reactions consistently? Do they have to become blind? Do they have to have heart disease? It's such a narrow dividing line that if we're doing it to allow the CDA access to the other provisions in the act with respect to the functions where it can deal with the community of people with diabetes, the class, then we're going to deal with everyone and bring everyone within the same rhetoric.

For persons who suffer a lack of respect in the community because they have diabetes, whether they have a severe case of diabetes doesn't really matter. It's the fact that there's a stigma attached to the disease. I think that's the same with many diseases that come within that category. There's been a body of systemic discrimination that is only now being dealt with. Policies have to change and so on. For example, again in the health care field, in the year 2000, how much of the resources are going to be allocated to the treatment of people with diabetes? That's going to be a very critical area that is going to require a lot of work, concern, lobbying and so on. Our view is that the more you do upfront, the less you have to do in terms of long-care treatment.

**The Chair:** Mr Harvey, on behalf of this committee I'd like to thank you for taking the time out this afternoon and giving us your presentation.

**Mr Harvey:** Thank you again for inviting us.

1420

#### ADVOCATES' SOCIETY

**The Chair:** I'd like to call forward our next presenter, from the Advocates' Society. Good afternoon. Just a reminder that you'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you would keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As



soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Ms Eleanore Cronk:** Thank you very much, Mr Chairman and members of the committee. We're pleased to be here before you again. I'm Eleanore Cronk, president of the Advocates' Society. With me are Mr Ray Colautti, a director of the Advocates' Society who will be speaking to you today, and our executive director, Mr Duncan Read.

We're grateful to the committee for the opportunity to address you again. We have read with considerable interest and study the proposed amendments to the collection of bills, in particular Bill 74. Our submissions to you today are going to be restricted to our further comment on matters that we raised with you when we were here before and how the proposed amendments respond or react to those.

We will be delivering our written submissions to you, which will be far more detailed, but we deferred that when we knew that the amendments were on board and in place. So I'd ask you now to hear from Mr Colautti, if you would.

**Mr Raymond Colautti:** Thank you. Mr Chairman, members of the committee, when we appeared before this committee on March 13, 1992, we expressed three basic concerns of the Advocates' Society on three essential elements contained in the proposed legislation as drafted.

The Advocates' Society is an association of lawyers throughout Ontario who practise as legal advocates in the resolution of disputes involving courts, administrative tribunals and governmental bodies, arbitrations and other forums. As such, many of our members have had experience dealing with vulnerable persons as they are described in this, the proposed series of legislation before this committee.

When we were here in March, the first concern we had was that the function of advocates is largely defined under Bills 108 and 109 and that the provisions of those acts empower and require the advocate to give advice to vulnerable persons concerning very fundamental rights of self-determination over themselves and their property. It is these people who are really in the greatest need of high-quality advice in so far as their legal rights and duties and responsibilities are concerned.

Our society was concerned that the legislation, as it was initially drafted, did not give enough guidance on the qualifications and training to be given to the advocates appointed under the act, or that it did not establish a code of professional conduct or a written complaints procedure where persons who are adversely affected by the actions of advocates wish to lodge a complaint.

There has been some addressing of those concerns in the acts as revised, but they do not go as far as our society would like to see them go, and we have some submissions we would like to make on that.

The second concern that we had expressed last March was very serious concern over the rights of entry conferred on advocates under Bill 74, particularly in respect of situations where private dwellings were concerned. We had felt and expressed to this committee that the provisions related to entry were overly broad and infringed upon deeply held values related to the sanctity of the home and

the right to privacy free from interference except in clearly defined circumstances. We had expressed a view that what in effect would be a forced entry for the purposes of access to a vulnerable person should only be sanctioned pursuant to a prior order given by a tribunal of competent jurisdiction. I have some submissions we wish to make on that point and some very specific concerns over the present wording of sections 18 and 19 of the act.

The third concern we had expressed was that we saw a potential for confusion created by the use of the term "advocate" for what is essentially social advocacy. An advocate's function, as defined under this legislation, really is giving more than legal advice, and there are many, many other manifestations of what they do. But we had expressed the submission that the use of the term "advocate," as it was explained in detail in some of the reports leading up to this legislation, has a legal connotation to it and could create confusion in the minds of the public.

Let me turn to the revisions of the act and how on those concerns that we expressed, we still have some further submissions to make and suggestions on how our concerns can be met by further fine-tuning of the legislation, if it is deemed advisable.

First of all, our concern over issue one—the powers, duties and responsibilities of advocacy and what I will call the accountability issue—has been dealt with somewhat under clause 7(1)(k) of the revised act. It does empower and direct the commission to establish minimum qualifications and standards and a code of conduct for advocates, but there are, so far as we are aware, no draft standards or code of conduct yet in place against which comment can be made as to adequacy or inadequacy. It is our society's submission that these standards should be in place before the act comes into force, and certainly before advocates actually start to be appointed under the act by the commission and start their function.

As an example, in a report dealing with the licensing of paralegals made to this government by Professor Ron Ianni of the University of Windsor, he proposed a very detailed and far-ranging licensing scheme that took into account training, educational standards, codes of conduct and so forth that should be applicable to paralegals. Paralegals really function in a quasi-legal sphere. They provide advice and legal services on a relatively low level, and it has been seen to be necessary to provide for qualifications, training, experience and code of conduct in a very detailed way in a report that was prepared after public hearings for paralegals.

As I opened my remarks to this committee, the people to whom the Advocacy Act is aimed in providing advocacy services are in probably the greatest need of high-quality legal advice in many circumstances. It is essential that the accountability issue be clearly addressed in a code of conduct and in a complaints procedure that is in existence before advocates become appointed. We see it as being absolutely essential that these standards be in place prior to the coming into force of the act in so far as the appointment of advocates is concerned.

For this reason, we suggest that in section 10 of the act, the legislation provide for an advisory committee



consisting of legal practitioners to assist in establishing these standards and providing advice to the commission.

We also suggest, related to this concern, that there be a structure enacted for providing legal advice to advocates so that they can discharge their duties effectively. We are not saying that all advocates must necessarily be lawyers or have formalized legal training; only that it is essential to have access to high-quality legal advice to enable them to discharge their duties effectively.

As an example, there is a body of expertise that has certainly been built up by the official guardian's office. They often act for persons who will be considered to be vulnerable persons under the proposed legislation. They have significant expertise in providing legal services to vulnerable persons. As we see it at this point in time, it would be desirable to have an interlocking of the function of the official guardian perhaps with the Advocacy Commission to provide that kind of advice that our society feels is absolutely necessary.

We also suggest that before a code of conduct and minimum standards of qualifications are propounded, there be a study or at least some sort of public hearing for input into what those detailed provisions would be, input as to content.

Related to our concerns over the accountability of advocates, we have some concerns over the phrasing of section 9 of the act. Section 9 of the act provides an immunity from lawsuits for advocates. As it presently reads, it provides for immunity from lawsuits against the commission or an advocate or other person who works for the commission or a community agency. That proposes a situation that even though perhaps an advocate performing his or her functions under the act is grossly negligent in the discharge of duties, the wording of section 9 as it presently stands does not provide for redress unless the actions of the advocate are motivated by bad faith. We pose the question as to why someone who has perhaps suffered serious damage through gross neglect or default of the advocate should not have recourse and a right to action.

We can understand perhaps the necessity of providing immunity to lawsuits to the commission that in many circumstances is acting much as a tribunal does, but to the advocates who are functioning there ought to be some greater accountability than is presently provided under section 9, and the minimum standard ought to be at least gross negligence.

1430

Turning to the second issue that we had previously expressed and still maintain, we have some serious concerns over the right of access under sections 18 and 19 of the act. We have a fundamental problem with the warrant procedures as they are laid out in the act, even as revised. The fundamental question that should be asked is whether it is appropriate and advisable to have the warrant procedure going to the forum of the justice of the peace.

Wouldn't it be better, we submit, to have a specialized tribunal deal with these warrant issues where there's a question of access and the right of access, particularly in respect to private dwellings? In terms of an advocate requiring that

access, wouldn't it be better to have a specialized tribunal deal with those questions as to issuing warrants?

A specialized tribunal has the ability to build up a body of expertise and precedent to guide it in situations where warrants are required. There is under the Consent to Treatment Act a proposal to set up a tribunal known as the Consent and Capacity Review Board. That would be an appropriate tribunal to discharge the function with relation to issuing warrants; much more so, in our view, than simply giving that function to a justice of the peace.

Dealing again with the right of issue, we have some very specific concerns with the present wording of sections 18 and 19 of the act, particularly with respect to access to private dwellings. Section 19 really deals, putting it in the vernacular, with access to private dwellings. Our society cannot support the right of entry without a warrant unless there are reasonable and probable grounds of imminent harm or mischief that might occur if access is not granted.

The way the act is phrased in section 18, an advocate is entitled to access without warrant if he or she has reasonable grounds. What we are proposing is that the words "reasonable and probable grounds" be added. That is a test that is well defined in law, has a great deal of precedent behind it as to what the meaning of the term is and provides a level of entry into private premises that is at least equivalent to what the police presently have. One might pose the question, in lessening the test to simple reasonable grounds rather than reasonable and probable, of why you are giving an advocate a means of entering a private dwelling that is greater than the powers enjoyed by the police at the present time.

Likewise, in section 19, in obtaining a warrant, whether the tribunal is determined to be a justice of the peace or a specialized tribunal at a future date, the test for obtaining the warrant should be that there should be evidence produced to a justice of the peace or the tribunal on reasonable and probable grounds to show that the conditions contained in clauses 19(1)(a) and (b) are existent.

The test for obtaining the warrant should be that there should be evidence produced to a justice of the peace or the tribunal on reasonable and probable grounds to show that the conditions contained in clauses 19(1)(a) and (b) are existent. That reasonable and probable grounds test is what the police must satisfy a justice of the peace about prior to obtaining a search warrant. Again we pose the question, why should the test be any less for an advocate?

With the same rationale, we also suggest that in section 17, even with respect to perhaps a facility or a controlled-access residence, the "reasonable grounds" that are expressed in subsection 17(1) should also be "reasonable and probable grounds" for entering. Those changes would bring this proposed law in line with a very well known and widely accepted test for intrusion into what would otherwise be private premises.

Dealing with the third issue, that is, the use of the term "advocate," in the O'Sullivan report, which is one of the reports leading up to Bill 74, the author looks at the definition of "advocate" and quotes from the Concise Oxford Dictionary. It is well known that the noun "advocate" is



one "who pleads for another"; who "speaks in favour"; "a professional pleader in a court of justice"; "a barrister." At page 40 of the report, Mr O'Sullivan says:

"As suggested by this dictionary definition, the most well known and best understood type of advocacy is legal advocacy, where a lawyer is retained by a client to plead a legal case on his or her behalf before an administrative tribunal or court of law."

We're concerned that the use of the term "advocate" carries with it a legal connotation that will cause confusion in the minds of the public, but in particular in the minds of perhaps vulnerable persons who may not be in a position to make very discerning distinctions on phrasing niceties.

We would request that this committee study whether other terminology can be used to describe what this advocate does, such terminology as "social advocate," or as is used in the Consent to Treatment Act, "rights adviser." The use of the term "advocate" has a danger of creating confusion in the minds of the public that we're very concerned about.

I thank you for your patience in reviewing our submission once again. We will submit a very detailed brief which will go into much more depth, but those are the three areas of concern we still have with the proposed legislation.

**The Vice-Chair:** Thank you very much. Any comments or questions?

**Mr Robert V. Callahan (Brampton South):** Mr Chairman, I am not a member of this committee, but I did speak to one of the members of the Advocates' Society and I think they're probably well positioned to perhaps answer a question that is not addressed. I put it on the record for purposes of this committee. It deals specifically with schizophrenics.

Under the amendments that were made to the Mental Health Act, a schizophrenic literally was allowed to refuse to take medication. I want them to validate that if a person did not take medication, was out of control and was charged with a criminal offence, something perhaps as mundane as being naked in a public place or committing some act that people didn't quite like in a public place, if he or she were to plead not guilty to that charge and then get on the stand to give evidence that perhaps the television set told him or her to do it, the crown attorney would immediately move to have the matter dealt with under section 16 of the Criminal Code as an application to have the person declared insane, which could well mean the person either pleads guilty to the charge and perhaps receives a discharge or a fine, or in the alternative, on an application under section 16, could wind up in Penetanguishene for an indefinite period of time at the pleasure of the Lieutenant Governor.

I'd just like you to confirm whether that in fact is the case. I remember when the amendments were passed to the act, everybody had this grave concern about forcing treatment on people. I can remember being on that committee and watching the mothers of schizophrenics, who sat in the front of the audience, not being able to have a word edge-wise about how their loved ones were being left out on the

street to jump off bridges or to perhaps cause more significant mischief by killing people or what have you.

1440

I've looked at this act. I've also looked very quickly at the brief from the Friends of Schizophrenics, and it does seem to address that in totality. It's like telling a person who's got diabetes: "You don't have to use your insulin any more if you don't want to. Just continue to have diabetes." Here there is medication and they can be treated.

I guess the question is—and perhaps you people would be good enough to either address it now or to address it from that aspect in a brief that might be sent in to the committee for the benefit of the committee when it deals with this bill in the House—is that in fact your experience? Perhaps I should ask the gentleman I was discussing it with beforehand.

**Ms Cronk:** I was going to say that, as a wise president, I'm going to defer that to the lawyer to my left.

**The Vice-Chair:** Just before you answer that, the parliamentary assistant would like to clarify that just for a second.

**Mr Malkowski:** I would like to clarify which bill it is that your question is concerning. Is it the Mental Health Act that you're actually speaking about or one of the bills in this committee?

**Mr Callahan:** It deals with Bill 108. I suppose it deals in a sense with Bill 108 specifically but perhaps with the other bills in a similar fashion too, as to whether or not these bills will have the impact of eliminating the tragic mistake we made in amending the Mental Health Act, at least in terms of schizophrenics, their families and loved ones, and how these people could be dealt with.

I can tell you quite frankly, from my own experience, the courts are fed up with these people being brought before them. I've had at least five or six judges say: "This is not a legal matter; this is a health matter. For God's sake, get your act together, Legislature, and do something about it."

**Mr Colautti:** You've asked a question, as I understand it, as to whether the scenario that you propose can happen. It's been my experience that, yes, it can and certainly does happen. What in essence happens is that the person ends up being detained actually for far longer in many circumstances than he would have been had he had the capacity to deal with this problem right at the start.

We would like the occasion to deal with that in our written brief, but a quick answer to your question is that it's been my experience that, yes, it can happen and does happen and that there is a real process problem concerning schizophrenics in this area that you proposed.

**Mr Callahan:** If you do that in written form, I'd like you to address the provision in here whereby even if a person gives a power of attorney for someone to look after their personal needs, the threshold for eliminating that power of attorney is much weaker than the one of getting it. He can literally discharge this person even though he may be on the fringe of going into a schizophrenic condition, a psychotic state.

Just for the record, I want the committee members to understand that we just recently read about a very tragic



event. I can tell you of events that I'm sure we've all experienced, and certainly I've experienced them significantly, where people who had not taken their medication were in fact threatening their family with all sorts of problems, including knives and weapons. The police are called. The police don't know what to do with them. There's not enough room in the hospitals if there happen to be cases a little more significant than theirs to put them in the hospital.

What happens is society as a whole—and I condemn the press as well. They only seem to write about it when somebody gets stabbed to death at night in his bed or jumps off the Gardiner Expressway. I put that on the record because I feel very strongly about it, that it's not an issue that's being addressed properly, even by these bills, and they require a significant amount of reworking to ensure that these people have that protection.

I think you'll also confirm that under our present—and I sound terrible saying this as a Liberal—Charter of Rights and Freedoms, in all its wisdom, a judge is prevented from even putting a term in the probation order that the schizophrenic take his medication, because it's been deemed to be contrary to the charter.

**Ms Cronk:** If I may, we will take a look at the issue and give you the best commentary that we can in our written submissions. What you've raised is obviously very fact specific; it's also very difficult. But we share your concern that there's a process problem and there's an exercise-of-rights problem in the hypothetical that you posed in the first instance.

What I did want, Mr Chairman, if I could, is to take one minute to supplement by way of comment on Mr Colautti's comments about our concerns about the warrantless-entry situation, so that this committee is very clear at least as to one perspective on the issue.

It's our view—and I think you know from the comments that we made to you when we appeared here before—that this legislation is long overdue and is a very laudable effort to help in a very much needed social situation. But there is, with respect to rights of entry, a balancing exercise that must be gone through. This act affords, for the very first time, extraordinary rights of warrantless entry to private dwellings.

Our submission to you in essence on that is that where there's a situation where there's imminent risk to the health or safety of a vulnerable person, then that's an exceptional right that society would not only accept but, in our view, would regard as laudatory. But where that test can't be met, where there isn't an imminent risk or safety issue, then it seems to us you shouldn't be granting to advocates or the persons filling that function—whatever in the end you choose to call them—rights that are even more extraordinary than those our police enjoy today.

What we're suggesting to you is that you revisit the circumstances in which someone can go in without a warrant where there is no imminent risk. We're suggesting that the test should be a well-recognized legal one, reasonable and probable grounds, and that this minimum threshold should be satisfied before warrantless entry to a private dwelling or to a facility should be permitted.

The people who addressed you in the previous submission from the Canadian Diabetes Association raised an issue that we're concerned about as well, and there were several comments from committee members. Very quickly, if I could comment on it, it's the issue of potential conflicts arising between the substitute decision-makers under this legislation, the persons filling the advocacy or advisory role, and the care provider.

Mr Colautti suggested you might give some consideration to the creation of a tribunal, which over time would build up the expertise and precedent necessary to deal quickly and on an emergency basis with some of the problems that are going to arise out of this legislation. The resolution of those kinds of conflicts is one of them.

Among the three of us here today, one of us is a lawyer who spends a great deal of time litigating and advising health care professionals in the disciplinary and non-disciplinary context. I can tell you that those kinds of conflicts arise on a daily basis, and there's going to have to be some independent arbiter that you can reach quickly to decide those kinds of conflicts. They're encountered every day by the trustees already in place to deal with those issues.

What we're proposing to you is that this is a model that can work. There are precedents out there, especially in the situation where children's rights are concerned, where it's already working, and that same body could deal with the issuance of warrants.

I want to underscore that we share the view that there is the certainty of conflicts arising among these various people involved in the process, and a tribunal could resolve those issues and could also deal with the issue of warrants. I've taken additional time, Mr Chairman. I thought perhaps I should at least try to do that.

**Mr Jim Wilson:** Thank you for your presentation. I was curious to know whether the term "advocate" appears in any other legislation that you're aware of, for instance, the Barristers Act. I'm not sure what we call it.

**Mr Colautti:** No, it doesn't. The Law Society Act speaks of barristers and solicitors, but, no, the term "advocate" is not used.

**Mr Jim Wilson:** None the less, your contention is that there may be confusion among the public. I don't really see that, although I recognize the legal profession obviously does advocacy and legal advocacy. We don't often refer to a lawyer as an advocate except in French.

**Ms Cronk:** Those who litigate do, if I may respond in that way.

**Mr Jim Wilson:** Is that right?

1450

**Ms Cronk:** It's a particular kind of lawyer. Our concern is this scenario: If you have a hypothetical where an entry has been made by this person, whether he's called an advocate or an adviser, in particular in a private dwelling, to see a vulnerable person, then unless there's explanation, if the name "advocate" is used, it can carry for those who are least able to question the implications of the language, the implications of the name, the implication that it's someone trained to give them advice on legal matters. They don't think of these things always as legal matters,



but these bills afford the right, for the first time, to decide issues related to personal property, personal health care, personal circumstances.

As you of course know better than I, that's a new element to outside, third-party advice. We're concerned that those who receive the advice will not differentiate between whether it's someone advising on substantive legal rights or advising in a different capacity. That's the first level of potential confusion.

The second is with the public at large, not just the vulnerable-person category. Really, what we see this act envisaging is people providing advice on basic rights and carrying forward the expression of the views of the vulnerable person. There are many ways to describe that without using the word "advocate."

We asked you before to consider using a descriptive, to call it a social advocate, something that would distinguish between a term that to many people in the community means a particular kind of lawyer. It's a barrister. That hasn't found favour with your committee. We're suggesting another solution. Call them advisers. Make it clear that they're advising on rights, that that's what they're doing, so that the person who is the recipient, the beneficiary of that role, isn't invited to conclude something else.

I can give you all kinds of examples, but the elderly person who is visited, either in a facility as defined or a private home, by one of these individuals, depending on what he or she did in his or her active life outside the home before coming to that, may have a very different word association with that name. All we're saying to you is that it does have a popular usage which refers to a very particular kind of lawyer, someone skilled in the law. It's a barrister. It's a trial lawyer. There are a lot of people who know the word in that context.

Our first position to you was adopt a descriptive: Call it a social advocate, call it a human advocate, something that distinguishes. If that doesn't find favour with you, call it an adviser. We're saying to you that legally there's some precedent to do it and that's the function we see them performing.

**Mr Jim Wilson:** I was a court clerk for a while and I should know these things, so I'm pleased you provided that explanation—obviously lower courts.

**Ms Cronk:** Or a long time ago.

**Mr Owens:** Just in terms of your comments with respect to the tribunal, I appreciate your suggestions and we'll certainly take a look at that. I think you're correct that at some point there will be some need for conflict resolution and it's clearly in the patient's, the client's, the individual's best interests to have that conflict resolved as quickly as possible.

I have another question around your comments with respect to, I guess, the discipline of the advocate, for the lack of a better word. Is it in your view that the duties of care, for the lack of a better word, that are imposed on the advocate are a high enough test on the advocate to ensure that he or she performs his or her functions to the best of his or her ability? In terms of the process that you see happening, if in fact that does not happen, do you see it

like a College of Physicians and Surgeons of Ontario model or a bencher model? How do you view the process taking place?

**Ms Cronk:** If I could respond to that, Mr Owens, again I said to you that one of the people who appears before you, as a matter of legal practice, spends a considerable amount of time doing disciplinary work for the physicians, nurses and police, as it happens. The model we had in mind when we suggested that, as you will certainly know, in most regulated professions, including the health professions, it is in the regulations that you find a definition of "professional misconduct" or "incompetence."

What we are concerned about with this legislation, as currently drafted, is that there's no clear description of what the duties of advocates are or a code of conduct they will be obliged to follow or, conversely, what might constitute misconduct.

We recognize that under the amendments it's suggested that's going to be covered by regulations. What we're suggesting to you is that you should have public consultation and public opportunity for comment, in the same way you have it here in the bill, about those regulations as soon as you can and before this bill gets implemented.

The reason for that, as you will of course know and the other committee members will know, is that the heart of that role is now going to be defined by regulation. I can't tell you whether we think there's a functional problem or a conflicts problem without seeing how that role is going to be described. Professional misconduct is going to be very difficult to define for this kind of person but you can define what's permissible and, to use your language, the minimum standard of care they're to employ.

That is not in this bill. It's been improved. There's a section there now, for example, that says the advocate can't do anything inconsistent with the expressed wishes of the vulnerable person. That's a threshold that's been established, but there's no clear articulation of what their function is, what their code of conduct is and what the rights of those who are adversely affected by them are going to be.

That's why in his submission Mr Colautti was urging you to get the draft regulations on the table now and to invite consultation from members of the public and interested groups. We see the regulation now as being key in the way it has been approached and we're urging you to use the model that has been used in other circumstances for health professionals and other people who are given extraordinary power, like the police, to deal with it in a very specific way, and it's not at the moment.

That's why we have the concern about the immunity section. It's usual, as you know, to put an immunity from law suits for damages in a statute for tribunal members. We're not objecting to that. What we're saying is you have a very broad immunity grant in here for people who are being given authority that at the moment even the police don't have. If you do that, you have to have your checks and balances in place. As we read this, you're saying that's going to be in the regulations and we don't know what's in them.

**The Chair:** You have one minute, Mr White.



**Mr Drummond White (Durham Centre):** Following the earlier line of questioning, Ms Cronk, you were discussing the issues with other health professions or social professions. The profession that most likely would be employed as social advocates here would probably be the social work profession, yet there is no law or social work act at the moment. The only way in which those codes of conduct would be defined would be in regulations. That wouldn't be as potent as having an act which defines the code of conduct for that profession, would it?

**Ms Cronk:** There's always a level of potency that's greater by having it defined in the statute than the regulation. It is possible, however, under the current bill that persons other than those with social work qualifications and training will function as advocates.

If you're going to create a category of people who have the kind of legal entry rights that you've given under this bill, what we're saying is make sure that under this bill you define it as well, and earlier rather than later. But, yes, you're right, there are other places to do it, but then you'd have to do it by cross-reference to another piece of legislation and you may have people who are not social workers exercising this function.

If you're going to permit that, if you're going to have a broader category of people who are eligible to function as advocates, make sure the code of conduct under their own operative statute is in place.

**The Chair:** Ms Cronk, Mr Colautti and Mr Read, on behalf of this committee I'd like to thank you for taking the time out this afternoon and coming to give us your presentation.

**Ms Cronk:** Thank you again.

**The Chair:** I'd like to call forward our next presenter from the Ministry of Community and Social Services. Good afternoon. Just a reminder that you'll be allowed a half-hour for your presentation. Do you have a statement?

**Ms Nicole Lafrenière-Davis:** No, we don't. We were asked to come to respond to some questions of the committee.

**The Chair:** Okay, we'll go straight to questions.

**Mrs Sullivan:** First, I want you to know that we appreciate you coming, and particularly at such short notice, to the committee. As you know, we have been dealing with four bills with respect to consent to treatment, substitute decisions and advocacy. In the course of the hearings on the amendments to those bills, we've had a number of interventions before the committee from children's aid societies and from other providers of services to youth, particularly youth with disabilities which are either mental or behavioural.

The concerns that they have raised with us are that the provisions of Bill 109, even with the Bill 110 proposed amendments to the Child and Family Services Act, will in fact interfere with the responsibilities and mandate under the CFSA in providing the services that they are statutorily required to provide.

We are concerned about that because we value the work of those agencies and believe it's important in Ontario and are eager as a committee to fashion amendments

which may be necessary to any one of the four bills that will ensure that their responsibilities under the CFSA are able to continue. We are at a loss to know how to do that; in fact, there is some question as to whether some of the unease which is being put before the committee reflects a valid concern. We wanted you to speak to that.

1500

We are waiting for a full briefing on the common law with respect to children's right to consent. We haven't had that yet. We hope we will have it before the end of this afternoon, and that may help us. But we thought that your practical experience with the CFSA might be of some use.

**The Chair:** Excuse me. Before your response, could you please identify yourself for the record?

**Ms Lafrenière-Davis:** Yes. My name is Nicole Lafrenière-Davis. I'm director of children's services branch, Ministry of Community and Social Services. With me is Heather Martin, who is a policy analyst with the ministry.

I must apologize first to the committee that the person with the most intimate knowledge of the issues related is on holiday, and I'll try to answer with the knowledge I have.

We're aware, of course, that the children's sectors have some concerns; they have been expressed to us; we have been talking about these concerns. The Ministry of Health and the Ministry of Community and Social Services have listened to them. At this point, we feel that until the acts are actually implemented, we're more or less trying to guess at what the implications are going to be.

We quite understand that for service providers who are having to understand and try to respond to their mandate, this is a very difficult situation. We quite understand as policy people that the CFSA was indeed established in order to try and establish a balance between the child's rights, the parent's rights and the best interests of the child.

What the new bills are doing is to say, and our ministry's position is, that where the child is found capable, then that child has a right to consent. That is our ministry's position in that balancing of rights and best interests.

**Mrs Sullivan:** I suppose that some of our concern is reflected in the changes which would affect the incapable child and the cross-relationship between those acts. With the capable child we understand the common-law provisions which encourage, to the best of that capacity, the decision-making in terms of, by example, consent to medical treatment. We know that in other acts there are obligations to allow the child to make as much of a decision as possible or contribute to those decisions and to accept certain responsibilities at certain ages.

In your view, and I know that this is difficult for you because you're not the political wing of the Ministry of Community and Social Services, would it be a practical approach to ensure that the work of service providers, who once again are statutorily mandated under the CFSA, is protected under that act, to indicate somehow in our deliberations that the CFSA is not affected by Bills 109, 108 or 74, and that this would be the best way of ensuring that the legislation, which appears to be working for service agencies, continues to work?



**Ms Lafrenière-Davis:** Part of your question would necessitate a legal opinion because there may be situations where you would have certain children who have different types of rights where you would have one act superseded, and I think that might be a question that legal services can answer.

**Mrs Sullivan:** We'll wait for the opinion from the counsel to the Ministry of Health, I suppose, for those instances.

**Mr Sterling:** I have had some difficulty in rationalizing in my own view the expense we'll necessarily have to spend on this Advocacy Commission in terms of the evidence that there's widespread abuse of vulnerable people in the province of Ontario. I guess I have even less confidence in spending the money on vulnerable young people in terms of the evidence that there are not adequate protections for young people at this time.

Subsection 3(1) of the act says that the act applies—I'm talking about Bill 74, the Advocacy Act—"in respect of vulnerable persons who are 16 years of age or older." The second subsection says the act also applies in respect of other people, in other words, people under 16, "for the purpose of providing rights advice and other advocacy services" under Bill 109 and the Mental Health Act and the Substitute Decisions Act, Bill 108.

I think a lot of our problems with Bill 109 as we saw them put forward particularly by people dealing with mental illness in adolescents, people between 12 and 16, could be put to rest, or partially put to rest, let's say, if in fact they didn't have to go—as I understood it, it's not so much that a rights adviser was there, but it's the process that is necessary in order to put this thing into play.

In other words, if you have a young person who is already rebelling against society, doesn't trust his parents, doesn't trust anybody, and you're trying to help him out, between the ages of 12 and 16, if you put a process in the middle of this emergency, then the ability of society to help that young person is going to be cut down substantially, or that's what we heard from Youthdale and we heard from other people who have to deal with these very difficult children.

You have all the experience compared to myself in terms of the protections that a young person has against someone involving himself or not consulting enough or the consent of the young person being taken away from him unjustly. Do you really see a need to protect the people under 16? Is it that critical at this time? Is there evidence of problems there?

We have the Child and Family Services Act, which is the balance that we heard talked about that tried to work out these things. Now we have the injection of this advocacy bill into that whole milieu or environment. I think we could put to rest the concerns with Bill 109 and the Advocacy Commission would be much clearer in terms of what its focus would be, and that basically would be vulnerable adults, and the other legislation would take care of vulnerable children. I thought that's what the CAS was all about and all the rest of it. Are there not enough checks and balance in there? I'd like your experience on that.

1510

**Ms Lafrenière-Davis:** I think what you're asking is a personal opinion.

**Mr Sterling:** Or a political opinion, maybe.

**Ms Lafrenière-Davis:** I'm not sure that I can give a personal opinion, again for the same reasons we've mentioned before. You have heard, and these concerns have been presented to us, both from the rights advocates, who feel that there is indeed a need to protect children's rights better, and from those who might be saying that we're pushing the pendulum too far. I think right now we are only able to guess what will happen when in fact the bill goes through, if it does.

**Mr Sterling:** Can I ask a specific question? An adolescent who's 14 years of age is rebelling against everyone and is brought into a situation where he needs treatment, medical treatment, let's say, or maybe for a mental illness. What kind of protections do they have under the present law? Take away this. Can you answer that in terms of—

**Ms Lafrenière-Davis:** We're assuming that we're still under CFSA.

**Mr Sterling:** Yes. The Advocacy Act doesn't exist.

**Mr Jim Wilson:** Essentially, delineate the provisions in the CFSA.

**Ms Lafrenière-Davis:** Okay.

**Mr Sterling:** I guess my question is, is this going to add anything?

**Ms Heather Martin:** Currently, a child who is in need of treatment who would be 14 years of age could in effect show up at a hospital, either at the request of his parents or at the request of the children's aid society. The hospital would assess whether that child was in need of treatment or not. If the child was refusing treatment, the hospital could require that the child remain for treatment, and/or if the hospital didn't feel it could make that disposition, the child could leave.

**Mr Jim Wilson:** Just following on that, Youthdale raised the concern that in a secure treatment centre there would now be a dual review process, one introduced by this new legislation and one under the CFSA—do you have any comments on that?—and that in fact the entire review process may last longer than the average 14-day stay, and that a child who really wanted to be obstinate could in fact just spend the entire time at Youthdale going through two review processes.

**Mr Sterling:** Without treatment.

**Mr Jim Wilson:** Without treatment. That seemed to be a very real concern of theirs, and I assume the ministry has heard of this concern. Any response?

**Ms Lafrenière-Davis:** We have indeed heard this concern. We've heard the concern about the process and the time lapse, which may, some service providers say, force providers into a more intrusive intervention than if they had been able to intervene earlier. We've also heard from some other service providers and professionals that professional skill in trying to get that child to understand the implications of the treatment being proposed can be



used in order to get the adolescent, even a rebellious adolescent, to understand the implications and indeed to agree.

**Mr Sterling:** Can I go back to the example you said there? There was one thing that sort of triggered my concern. You said that if the young person, the 14-year-old, shows up at the hospital and is advised of the treatment and the parents or the CAS and the doctor etc try to convince the person to undertake that treatment, there's nothing they can do to coerce that person to take the treatment, as I understand it, under the present law, so the person can walk.

All this act would do would be to inject a process and have an advocate or a rights adviser, if one was available, come into this scene. Of course the argument we have heard here is that all this can do is cause harm because of delay, and perhaps getting the wrong answer as well. The health care people and the CAS don't like getting the wrong answer.

What I would like to know is, are there complaints by young people who have been treated, after the fact, that they were coerced into having treatment? Is there any record of that?

**Ms Lafrenière-Davis:** I can't say. In my branch, and again I'll have to talk to my branch, if there have been some complaints, they would be with the office of child advocacy.

**Mr Jim Wilson:** Perhaps you could tell me. Under your legislation, the Child and Family Services Act, upon admission, or in the scenario we're using here, just to continue it, are the children advised by the physician or someone at the scene that they have the right to walk and to refuse treatment?

**Ms Martin:** They should be.

**Mr Jim Wilson:** It's a requirement in the act, is it not?

**Ms Martin:** Yes.

**Mr Jim Wilson:** So what are we doing by introducing a rights adviser to the scene? Would not the rights adviser simply tell them what they're already required to be told?

**Ms Lafrenière-Davis:** I think it would do more than that. I think under the proposed recourse there's actually a process that would be described to them. I think it would be a much more precise explanation of what the rights are.

**Mr Jim Wilson:** In terms of a person who's been deemed incapable, then the rights adviser of course would be able to tell him or her, "You have the right to object to this finding and here's the process," type of thing.

**Ms Lafrenière-Davis:** But the health practitioner, under the proposed legislation, would have to inform the child 12 and over that he is finding him incapable.

**Mr Jim Wilson:** Okay, and under the current situation that's the case. The health practitioner would inform the child that he's finding him incapable. What current rights does the child have under the CFSA then, after that point?

**Ms Lafrenière-Davis:** He can leave.

**Mr Jim Wilson:** The child can still object to the treatment and walk.

**Ms Lafrenière-Davis:** Yes.

**Mr Jim Wilson:** So I guess what I'm trying to figure out is, are we helping things or hindering things?

**Ms Lafrenière-Davis:** I think, if you're using your initial example of a child who is a 14-year-old child, and if he were found incapable, which is the situation we're talking about, under current legislation parental approval would be sought. A parent can give approval under current legislation.

1520

**Mr Sterling:** Can I ask this another way? What is the difference between how we treat a child who walks in, a 14-year-old, versus somebody who's 18? Is there any difference in terms of the protections of those two people as to how they are treated by the hospital?

**Ms Lafrenière-Davis:** Under current legislation?

**Mr Sterling:** Yes.

**Ms Martin:** Parental role would figure in for the child who's under 18.

**Mr Sterling:** And it would not otherwise?

**Ms Lafrenière-Davis:** Not for an 18-year-old.

**Mr Sterling:** So under 16 under the present law. If the 18-year-old were incapable, what would you do, or what happens to the individual?

**Ms Martin:** It would depend on whether the 18-year-old was in the care of a children's aid society or whether the 18-year-old was living at home with his parents. If he was living at home with his parents, the 18-year-old would basically be in charge of himself. The 18-year-old who is in the care of a children's aid society would be dependent upon the kind of order that existed in the children's aid society.

**Mr Sterling:** But if they were incapable and they said, "I don't want the treatment," they could walk out of the hospital and nobody else would be called in to try to convince—

**Ms Martin:** If they were between 16 and 18.

**Mr Owens:** I guess I have a fairly general question from the operational perspective of the ministry with respect to the Child and Family Services Act. If and when this legislation is passed, the various child service agencies have predicted dire consequences and an inability to treat children and all sorts of other catastrophic events taking place.

Is it the view of the ministry that the status quo will reasonably remain in force, especially with respect to the children's aid societies? Do you see these kinds of difficulties that they seem to predict arising, from your perspective?

**Ms Lafrenière-Davis:** There is no doubt that if legislation does go through, there will be an impact on service providers. They've made that clear to the ministry and to the committee. As a ministry, what our stance would be is post-legislation to discuss with the societies how they're going to be able to live with the new legislation, if they will have to negotiate different protocols, if they will have to change their internal policies. This discussion would



take place with the societies to discuss what they feel is their impact.

**Mr Sterling:** I just have one question that relates to what Mr Owens said. I would debate him with regard to his characterization of the CAS, Youthdale and other people who are caring for young adolescents as saying that this is going to have dire consequences and the world is going to fall in. That is not the way they characterized it, as far as I was concerned, on this committee. In my view, they said there was going to be a great deal more difficulty in delivering their service. None of them said they were going to back away from their commitment to providing those services. In my view, they were not trying to exaggerate their position excessively.

**Mrs Sullivan:** I want to go back to questions relating to the emergency admission to secured treatment facilities, which was an issue that was placed before the committee in some detail.

We certainly know that while there are few young people in terms of numbers who are affected by those provisions, the Child and Family Services Act is broad in terms of the obligations on the care giver, on the parent and on the children's aid society, if the child happens to be in care, and includes, by example, rights advice for the young person, a route of appeal which will in fact, under the normal provisions in Bill 109, create a complete new process of rights advice and appeal, and indeed there may be some concern as to whether the consent-to-admission requirements of the Child and Family Services Act aren't completely taken out under Bill 109 if they no longer exist.

How is a social worker with a children's aid society, who has taken a child into care for the protection of that child, as he's obligated to do, to know what act is his guiding act, what services he is mandated to provide, what steps have to be taken along the way? Given very similar issues, whether it's rights advice or ensuring consent or treatment or providing consent itself, why should that social worker be put in a position of requiring the child to go through two processes, each of which may be intimidating, and also the health practitioner having to deal with the two processes? What's your advice going to be to the social worker? Where should the social worker take his or her direction from, the Child and Family Services Act or Bill 109?

**Ms Lafrenière-Davis:** I think my answer would be close to the answer I gave Mr Owens earlier, that should the legislation go through, there would have to be extensive retraining of the child protection workers and social workers in the agency in order to advise them of the steps that need to be taken and how they can really exercise their professional skills to make this as easy and understandable a process for the child as possible.

Some of you may remember that when the CFSA was passed, there was indeed a lot of controversy. There was a lot of training that was needed and the CASs put in place certain policies and guidelines to permit their staff to do the best job possible in protecting children. The same thing would happen post passage of this bill.

**Mrs Sullivan:** As policy advisers—this is going to be a tricky question; you don't have to answer it—do you

think it's appropriate and would you be provided policy advice that would say that there is any reach into the best interests of the child to require the child to go through two review processes instead of one, which is what will happen?

**Ms Lafrenière-Davis:** I think we would have to decide at that time what would be our best advice.

**The Chair:** On behalf of this committee, I'd like to thank the Ministry of Community and Social Services for coming and answering some of the questions raised by this committee.

#### ONTARIO ASSOCIATION OF NON-PROFIT HOMES AND SERVICES FOR SENIORS

**The Chair:** I'd like to call forward our next presenters from the Ontario Association of Non-Profit Homes and Services for Seniors. Just a reminder that you'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you would keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourselves for the record and then proceed.

**Mr Paul O'Kafka:** Good afternoon, Mr Chairman. My name is Paul O'Kafka and I'm executive director of St Joseph's Villa in Dundas and president of the Ontario Association of Non-Profit Homes and Services for Seniors. With me is Michael Klejman who's our executive director at OANHSS as well.

The Ontario Association of Non-Profit Homes and Services for Seniors is a non-profit, charitable corporation which has been in existence since 1919. Our mission is to support and advance the interests of our members, thereby enhancing their ability to meet the needs of the individuals and communities they serve.

1530

OANHSS represents over 200 organizations providing services to some 140,000 seniors, or over 10% of Ontario's elderly population, through non-profit homes for the aged, seniors' housing and community support service agencies. Membership of the association is comprised of municipal and charitable homes for the aged which operate a variety of programs and services for seniors. Origins of our member non-profit homes go back to the mid-1830s and reveal a proud history of innovative and responsive programs which are reflective of the needs of the diverse communities in Ontario.

In March of this year we appeared before this standing committee and presented a submission on bills dealing with advocacy, substitute decision-making and consent to treatment. In May we received copies of the three bills with amendments proposed by the government, and now we appreciate the opportunity to comment on these amended bills.

In our original submission we supported Bills 108 and 109 while recommending some amendments. We're pleased to see amendments proposed for both bills, particularly the emergency treatment of incapable persons in Bill 109. In this submission we'll focus on Bill 74, the Advocacy Act.



Before doing that, relating to Bills 108 and 109, on Bill 108 our association endorses this bill but wishes to recommend that the title "advocates" throughout the bill be replaced with the term "rights advisers" to more properly reflect the role fulfilled with respect to the provisions of this bill. In terms of Bill 109, consent to treatment, we endorse this bill as it's been amended.

**Mr Michael Klejman:** This is Michael Klejman and I'm the executive director of the association. Turning to the third legislation, we would like to declare that we interpret the provisions of this bill from the perspective of elderly persons, who are the consumers of our services. We wish to stress the fact that there are many factors, physical, psychological and environmental, which affect the vulnerability of older persons, but at the same time not every 90-year-old person is automatically vulnerable due to the age factor alone. We believe that needs and circumstances of seniors who may be vulnerable differ significantly from other groups of vulnerable persons. This is why we continue to have concerns about the viability and appropriateness of putting all potentially vulnerable persons under this single piece of legislation.

We support many of the amendments which have been proposed, particularly those which establish an advisory committee, suggest a positive role of families and set out advocates' responsibilities.

We continue to have some concerns with the scope of power vested with the advocates. It is difficult to find many other examples where individuals without prior extensive training and a licensing process are entrusted with the power to pass judgements as to vulnerability and then to act on these judgements. In our recommendations, we aim to address this concern.

We submit to the committee the following amendments to Bill 74:

We recommend that the word "perceived" be deleted from section 2, the definition of "vulnerable person." We believe that advocates must base their interventions on information and on observations. It would be inappropriate and potentially dangerous to base interventions on speculations as assumptions made by advocates.

We further recommend that the Advocacy Commission be given the task of defining, either in regulations or guidelines, circumstances when advocates' involvement would be appropriate. We believe that where there are primary care givers, such as families, then the advocates' involvement, if required, will need to take a different focus.

We also recommend that advocates' rights of entry to care facilities, as stated in subsection 17(1), be the same as those applied to other premises. Subsection 18(1) details conditions when premises can be entered. We would like to see these very same conditions apply in subsection 17(1).

Before an advocate can have access to records without consent, an assessor, as defined in Bill 108, must assess the vulnerable person as incapable of giving consent. As stated above, we have concerns that advocates, in several instances, are empowered to act as both the judge and the jury.

In another amendment we suggest that the mandate of the advisory committee be detailed in regulations and should include giving advice on such matters as qualifications,

standards and a code of conduct for advocates, procedures for dealing with complaints and specific guidelines for involvement of advocates. The amendment creating an advisory committee needs to be supported through provisions spelling out the role and responsibilities of such committees.

Finally, we urge the government to stage the implementation of the advocacy program in two phases. The commission should be created and given the time to carry out its developmental tasks, which would include drafting of regulations to the act. Only when this task is completed should the advocacy program itself be introduced.

This, members of the committee, concludes our presentation, and we'd be glad to answer any questions you have.

**Mr Sterling:** I'm concerned somewhat, as you are. I don't disagree with any parts of your brief and therefore am very supportive of some of the amendments you're looking forward to. The part I guess I'm concerned with is the advocate's access to medical records. What is your understanding of their limitation? For instance, is it clear to you what an advocate must do before he asks for this record? Does he have to have a written direction from the vulnerable person? I practised law before I was engaged in politics, and before I acted on behalf of somebody I wanted to be certain that he retained me to do whatever I was going to do. I'm not clear what an advocate has to do in order to gain that authority.

**Mr Klejman:** Your question, as I see it, relates to one of our proposed amendments. I agree with you that the concern is that, in effect, if an advocate judges that an individual is incapable of making a decision as to whether there should be access to medical documentation, whatever documentation may be in a facility or a care setting, then the advocate simply requests those documents. Whether it's done in a written form or verbally is not spelled out, obviously, in the bill right now, but it appears to us it is to be that simple: Simply ask for whatever documentation may be on file in that setting.

**Mr Sterling:** Perhaps the parliamentary assistant can answer me. What kind of authorization must an advocate get before he asks for a medical record of a vulnerable person?

**Mr Winninger:** Which parliamentary assistant are you seeking an answer from?

**Mr Sterling:** Either.

**Mr Malkowski:** I'd like to refer the question to Mary Beth.

**Ms Valentine:** It's my understanding, once again not being legal counsel, that issues such as forms and releases, those types of things, get developed during the regulation process. We certainly heard a number of times during presentations that there will need to be consultation on issues of this sort as regulations are developed. Regulations will be brought forward by the commission and presented before they are put into place. A consultation process would take place. The access issue is the development of a release-of-information form. Those types of things would be developed during the regulatory phase.



**Mr Sterling:** That's not a very good answer.

**Mr Winninger:** I thought it was.

**Mr Sterling:** What it's saying is, "We'll make up the rules later as to whose information we can get."

**Mr Winninger:** We're just discussing the issue of forms, if you were concerned what kind of form would be used to give authority—

**Mr Sterling:** No, I'm not concerned about a form. I don't care about a form. I care about the fact that an advocate can get access to a vulnerable person's medical records without any authority.

**Mr Winninger:** The consent would flow from the vulnerable person. If the vulnerable person were incapable of giving consent, then the substitute decision-maker would give the consent. But it wouldn't be without authority.

1540

**Mr Sterling:** Where does it say that in the act?

**Mr Winninger:** Let's go to the section. Section 27?

**Mr Sterling:** It's section 24.

**Mr Klejman:** I believe it's subsection 24(4) that gives the advocate the right to obtain that information.

**Mr Sterling:** Does he have to refer to anybody? Does he have to go to the commission? How many people are involved in this decision? Is it just the advocate alone who makes this decision?

**Ms Valentine:** Excuse me. You have to go back and look at section 15. The whole issue has to be read in relation to the role of the advocate, the advocate's relationship to substitute decision-makers etc. The advocate has consent of the vulnerable person who is able to consent. If there is a risk of serious harm to health or safety is the only time that there's any ability for an advocate to have access without consent, and it's limited to that specific situation. At any other time, if there's a concern about care etc the advocate is to be provided the name of the substitute decision-maker, guardian etc, whom he may make contact. If the substitute decision-maker wishes, he can provide consent to the advocate.

**Mrs Sullivan:** Mr Chairman, I beg to differ. I think under section 25 that's not correct. The advocate can have access to a vulnerable person's records with the permission of the commission for the purpose of systemic advocacy. But none the less, those are individual records, clinical records and other records.

**Ms Valentine:** They are not personal identifiers in relation to systemic advocacy. It's the same type of access that is now currently available for research. That's subparagraph ii of paragraph 2 of section 27.

**Mr Sterling:** If a person is incapable, is he capable of giving consent?

**Ms Valentine:** Is the issue whether the person is capable of giving consent to the advocate to access his records?

**Mr Sterling:** Yes, but if they are incapable to reason?

**Ms Valentine:** I think, as we've heard numerous times and as outlined in the guardianship and the consent legislation, consent is based on the specific issue at hand, so there's not a blanket determination that a person is incapable for

every facet of his life, unless that person is conscious or something to that effect. Each issue has to be dealt with at the time. Perhaps people relating to the consent legislation would like to further address that.

**Mr Sterling:** Whom is the advocate accountable to with regard to this information?

**Ms Valentine:** To the client, primarily. Again, the confidentiality provisions are very strict disclosure guidelines and with personal penalties for the advocate for inappropriate disclosure.

**The Vice-Chair:** Thank you very much, Mr Sterling. Any more comments or questions? Seeing none, I want to thank you for taking the time to appear before us today.

**Mr Klejman:** Thank you.

**The Vice-Chair:** Next we have the Canadian Mental Health Association, please.

**Interjection:** Can we recess for two minutes?

**The Vice-Chair:** We are recessed for two minutes.

1548

#### CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO DIVISION

**The Vice-Chair:** I'd like to call this back to order. You've up to a half-hour for your presentation. The committee would appreciate it if you would leave some time at the end for some questions and comments. You can begin any time you like. Would you please read your names into the record.

**Mr Hugh Tapping:** My name is Hugh Tapping. I'm a member of the board of directors of the Canadian Mental Health Association, Ontario division. I am chair of the policy advisory committee. I'm here today with Carol Roup. She is our senior director of policy, research and branch services, and the acting executive director during vacation time.

We do not have a written submission for you this time. We suspect that you've already read enough, in addition to which we frankly did not had enough time to do as adequate a job as we would have liked if we were going to be committing ourselves to a formal presentation on paper. So this is going to be a little informal. I also suspect that you've probably just about had enough by now anyway. There's one more presentation to go and it'll be time for clause-by-clause.

This invitation to comment on the proposed legislation, as amended, is almost an honour for us to be asked to come back and talk yet again about it. We're most pleased with the efforts that we have seen by this committee, this government and the opposition parties in bringing this legislation forward. We believe the many amendments we have seen have improved things a great deal. At the same time we still think it is not perfect. We don't think it ever will be perfect.

Some of our issues this committee listened to are most gratifying to see, such things as the role of families, for instance. This wasn't difficult for us; we've just been continuing to advocate along the lines of the positions and approaches we've been talking about for a long time. Other positions have not been so easily arrived at.



We are members of the Ontario Advocacy Coalition. We support the advocacy coalition's brief to you. We did have a lot of trouble with the notion of partial guardianship legislation. It's one of those things that used to be called a conundrum, also known as "damned if you do and damned if you don't." We have long advocated for at least restrictive alternatives. At the same time, we do have a lot of experience in this field.

One might have expected that a proposal of less than complete loss of autonomy wouldn't have presented a problem, but it did. On one hand, there is this appearance of a minimal sort of intervention. But history gives us some warnings here. Partial guardianship could be the thin edge of the wedge leading to an incremental loss of autonomy. Partial guardianship could also just plain appear less intrusive than what it actually is, and therefore it will be very easy to come up with implementation of this legislation, placing people under partial guardianship.

We have been monitoring and doing our own sorts of advocacy for a very long time. Over time, things do get better. As a citizen organization, I guess it's part of our job to remind people who make legislation that it isn't only the legislation that makes changes happen. For instance, the proposals we have seen have generated some publicity, not a lot, in the press—pretty negative stuff, a lot of it. It's especially concerning when we see objections being raised to things that are not in the act in any way, shape or form. We've heard many concerns raised about children and about people who really need help and don't want it and so on.

By nature, it's going to be the big problems that are going to be bringing themselves to the advocates, to the Advocacy Commission; it's not going to be nickel-and-diming people to death. That is not the intention of the legislation, nor is it going to be the intention of the people who will be on the Advocacy Commission.

From the viewpoint of the Canadian Mental Health Association, we support the amendments that have been proposed. We must see this legislation passed as soon as possible. It is not possible to continue refining this without seeing it drop off the legislative agenda. It has been a decade or more that all of the political parties have been addressing this issue. There have been reports, there have been reports and there have been more reports. It's time now to proceed.

As I said, the legislation is not and cannot be perfect. It is important that there be some sort of ongoing review and consultation, not about the legislation in and of itself but about the Advocacy Commission and the advocates' work. Knowledge must be accumulated. We have big-picture reports. We need to get this commission going so that specifics and details can be learned and patterns spotted that now are just anecdotes.

I'm going to turn it over to Carol Roup, who will address some of our issues with the proposed amendments. At the end, if there is still time for questions and so on, I might have a few other things to say.

**Ms Carol Roup:** My name is Carol Roup. I'm the senior director of policy, research and branch services for the Canadian Mental Health Association.

For the record, I should just remind everybody that through 35 branches located across the province, a range of community mental health services and programs are provided by the CMHA to local communities. These services include employment, housing, social rehabilitation, case management, advocacy and public education. With advice and input from both staff and volunteers involved with the provision of these services, the Ontario division devotes considerable effort to ensuring that policies, practices and legislation respect the human and legal rights of people with mental disabilities. In this respect, the Ontario division board of directors places a very high priority on the organization's role in systemic advocacy.

Our organization, as Hugh said, is an active member of the Ontario Advocacy Coalition, which presented its response to you last week. We are here in support of the position of the coalition and wish to commend the co-chairs of that very special coalition for leading us through a very thorough, open and educational process, the outcome of which we believe has led to the coalition's very thoughtful recommendations.

As Hugh has said, we were very pleased to note that various amendments reflect changes in areas where our organization did have concerns. In particular, we were pleased to note that the notion of partial guardianship remains in the legislation. We are still supportive of and committed to that. We are also very pleased to note that the amendments provide for an advisory committee to the commission, which will facilitate the voice of family members in particular, and service providers as well as the community.

In general, we believe these amendments have achieved a sensitive balance of interests and a greater clarity of purpose and intent of the legislation, especially with respect to the role and responsibilities of advocates. I think this was quite misunderstood around the first set of responses and I think it's much clearer in the amendments now.

However, we do wish to lend some support to several issues the coalition has highlighted that still need attention. With respect to the Advocacy Act, we have one point. This has to do with section 15, which is on page 10 of the act. This is the provision that exempts organizations representing people with neurological disabilities from the general rule that organizations participating in the Advocacy Commission appointments process must have, as the majority of their members, people whom the organization represents.

I believe that Mr David Baker, executive director of ARCH, has provided this committee with excellent arguments in this regard. The CMHA supports the position that this position is unacceptable. Given that the amendments provide for the voice of non-disabled family and service providers, it is quite unnecessary to place this barrier in the way of those with neurological disability from organizing themselves and speaking for themselves.

With respect to the Substitute Decisions Act, we have two points to make: The first point has to do with section 15, which I believe is on page 9 of the act. This section provides for the public guardian and trustee as statutory guardian of property. We support the position of the OAC that Bill 108



provides a fair and efficient means to determine capacity and appoint a substitute for Ontarians in all settings.

As the OAC's brief points out, the key feature of the SDA is the authority, while competent, to execute a power of attorney to select the person whom one wishes to manage one's affairs in the event of a subsequent incompetence. However, section 15 makes the public guardian and trustee statutory guardian whether or not the patient has previously executed a power of attorney naming someone else.

The coalition has suggested changes to the Mental Health Act while at the same time maintaining the requirement that every newly admitted psychiatric patient is assessed for financial incompetence. If the individual is found to be incompetent, the public guardian and trustee would be notified for the purposes of invoking the process of the Substitute Decisions Act as described in section 16, and we would support that amendment.

A second point with respect to Bill 108 is about clause 56(4)(a). This clause addresses a guardian's authority to admit a person to a psychiatric facility. The CMHA believes that the Mental Health Act adequately provides for involuntary admission to a psychiatric facility when mental disability may result in (1) serious bodily harm to the person, (2) serious bodily harm to another person or (3) imminent and serious physical impairment of the person. There appears to be no reason to authorize forced hospitalization when none of the above criteria are met and the person has never indicated, while competent, a wish to be admitted against his will during a period of incapacity. We would recommend that the suggested new subsection being recommended by the coalition be reconsidered.

1600

With respect to the Consent to Treatment Act, we have one point. This has to do with subsection 1(1), page 3 of the act. This subsection allows regulations to be passed which allow certain persons who do not work for the Advocacy Commission to provide rights advice. Again, we support the OAC's suggested amendment, which addresses potential conflict of interest by excluding individuals who provide services from becoming rights advisers.

That concludes the specific points we wish to make. I would like to reiterate Hugh's points, and in particular stress the importance of putting this legislation in place. The CMHA strongly recommends that, without delay, the commission be established, properly resourced, and that trust be placed in the commission to carry out ongoing research into its effectiveness for vulnerable people.

Our organization would also like to emphasize the importance of a broad public education process, and to recommend that a mechanism for ongoing monitoring, consultation and evaluation of the legislation be put in place. As Hugh said, only time and experience will advise us all on its workability, and certainly no more consultations are necessary.

**The Chair:** Questions and comments?

**Mrs Sullivan:** Thank you. I would be interested, knowing the broad kinds of work the Canadian Mental Health Association does, in whether you are satisfied with subsection 7(2) of Bill 74, which would mean that an

organization such as your own could not be authorized by the commission to provide functions that are set out in clauses (1)(a), (b) and (c), including providing advocacy services on behalf of the commission. Why do you think your organization should be excluded from that involvement with the commission?

**Mr Tapping:** A two-part answer. Carol first.

**Ms Roup:** Our organization struggled a great deal with this. A number of our branches are forced to do advocacy for one reason or another, and at times have been put in positions where they have to do personal advocacy and take on roles that perhaps are not appropriate, but because it's the only agency in town, it has done this for compassionate reasons.

However, we have come to the conclusion that the fact that we provide services really is a conflict in terms of providing advocacy under the commission. I believe we could do all kinds of systemic advocacy work and we could continue to do much of the work we do, but in terms of operating under the commission, we are supporting the fact that providing services and being an advocate at the same time poses a conflict. Several of our branches which do that kind of work have suggested that, at times, the fact that they provide services gives them the kinds of insights they need to do better advocacy. I'm sure that's true under certain circumstances. But I think that, as a principle, service providers who try to be advocates at the same time are placed in incredibly difficult positions. So we are supporting that.

**Mrs Sullivan:** I suppose one of the issues that is problematic here is that, on a regional basis, there will be people in various parts of the province who have been dependent on organizations such as your own, through regional branches or local operations, who will have less access to advocacy services.

**Ms Roup:** Except that I expect that our branch services will have the ability, on the advice of a vulnerable person, to alert the commission. It's not abandonment, I hope, but I think there's a legitimate role for a commission in terms of advocacy services.

**Mr Tapping:** One of the factors that led us to take this position, which admittedly does look kind of strange—it's cutbacks time, it's reallocation of resources and all of those good words and here we are coming forward saying, "Thank you, we don't want to do this," even though there are economic interests that would say that we could, perhaps, try to do this. But we'd be placing ourselves, our branches, our programs, in harm's way, in a position of temptation. It is not fair.

We have mental health in the workplace projects, too. It's not fair having somebody in this office raising a ruckus about something that the person in the next office has been doing. Our understanding of the way people work is that you'll end up having something less than the kind of advocacy that the person who needs and wants that advocacy is looking for. We could place our own employees in a position of conflict of interest, and as we all know, that leads to morale problems and so on.

We don't want to be all things to all people. I really don't see this as being a replacement for the kind of ongoing



advocacy of many kinds that's done already. We see this as an addition to it. We also see a place where we're into catch-22, and there's nothing we can do now except grin and bear it, of having somewhere else to steer a person to, where there would be the time and resources available.

**Mr Sterling:** I just have a comment, and I want you to know that both opposition parties were instrumental in having these hearings on the amendments. It was only through us standing up and saying there were 199 amendments to the bills and it was necessary that the government have a second chance for people to talk again did these hearings really take place. I congratulate the government for acceding to that request.

Also, I want you to know, the opposition parties, in order to get these hearings, had to give up some rights that we have in the Legislature. That is that we continued our position that we would be cooperative and constructive in trying to get this thing through within a reasonable time frame. So we have restricted our ability, when the legislation goes back to the House, to obstruct, to drag it out or whatever it is.

No question we play politics in order to put forward our positions, but we recognize that it is time to resolve these issues and that we're going to have to do it. It doesn't matter whether the Liberal Party or the Conservative Party forms the next government, or the NDP, whoever it is has to resolve the problem. We've recognized that and I want you to know that we have worked through these long hearings etc not because we love to be here but we thought it was necessary. Quite frankly our only concern has been that we have not had a focus on it by the ministers who are responsible for the legislation that we would have like to have seen. We think this legislation is that important that we would have liked to have had more ministerial participation.

**Mr Owens:** I just have a comment as well, and perhaps you'd like to respond to it, either Mr Tapping or Ms Roup. In terms of your comments with respect to guardianship, I empathize with them and am slowly, or rather I should say quickly, coming to the view that perhaps if we are to have guardianship provisions they need to operate on two different levels. One level would address the types of difficulties that have been expressed by organizations like Ontario Friends of Schizophrenics that have some extremely difficult situations to deal with in terms of having their children or adults in their families treated.

However, what I do hear from presenters like yourself and presenters like the Ontario Association for Community Living and People First of Ontario is that there has to be a strong sense that independence is going to be maintained for individuals and lengths are going to have to be taken to assure that a person is just not put into guardianship without some kind of extraordinary process taking place.

As I say, we need to have language that addresses the catastrophic issues, but also we need to address the independence of the individual, such as people from People First, persons with communicative disorders, so that we don't just assume.

We're talking about reallocations and cutbacks. I guess my concern is that what may happen is that service providers,

with money at a premium, will not have the ability in their view to go that extra length. It will simply be easier to place a person under guardianship, and we need to prevent that kind of thing from happening.

1610

Again, your comments with respect to making sure the commission is well resourced are dead on. This is not a program that can be started by this government, and at some point in the future when we cease to be the government the incoming party removes the funding or downgrades the funding level that's required. This is just not something that can be stopped and started on a whim. We are clearly talking about people's lives in this process.

**Mr Malkowski:** Thank you for your presentation today. I'd like to respond to your concern related to neurological disabilities organizations and the fact that they are not able to participate in the nomination process. Subsection 15(2) talks about exceptions in cases of organizations that are referred to in paragraph 6 of subsection (1). I'm wondering how you feel about that.

**Mr Tapping:** It is extremely strange, from my personal perspective, to see this inclusive cross-disabilities method of organizing and structuring the Advocacy Commission and then turning around and doing a list of exceptions. I am not aware, for instance, that any of those members of the bar association who have epilepsy, which is a recognized neurological condition, are also vastly incapacitated, or they wouldn't be functioning as lawyers.

There's a member of a provincial Legislature in this country who has Alzheimer's disease and is out of the closet about it. There have been suggestions there's something wrong with a great number of our elected representatives, but why make these exceptions? They stand out because there is no explanation as to why this, that or the other group is so completely incapable of running their lives, their organizations and so on.

You heard from David Baker that there are already groups of people out there with those labels. It just makes no sense to us to exclude them. As I said, it simply stands out. There is no explanation as to why when we're looking at all these different groups who have what we call disabilities or handicaps. Why put a rider on it? Unless there is some logical explanation for it that has not been shared with the people of this province, I'd be quite comfortable with seeing it just dropped as an issue.

**Mr Sterling:** I'd just like to make a point of clarification.

**The Chair:** Mr Malkowski is still—

**Mr Sterling:** It's just a point of clarification, Mr Chairman. It's a requirement, when you're a member of the Legislature, that you have a neurological impairment.

**Mr Tapping:** Thank you, Mr Sterling. I'd long suspected that.

**Mr Malkowski:** I think we will be considering taking out that exception, so I think we are going to be addressing that concern.



**The Chair:** Mr Tapping and Ms Roup, on behalf of this committee I'd like to thank you for taking time out this afternoon and giving us your presentation.

**Mr Tapping:** We've got one more minute left and I'd like to remind you folks we've got one more to go. I want to give my motivational speech here now. I hope you've all seen Ernie Lightman's report. I doubt anyone has read it yet in its entirety. I haven't.

Many vulnerable adults in Ontario live in conditions that we associate with the poor of Victorian England, not with residents in late 20th-century Canada. Ontario citizens, voters, with psychiatric histories are living six or more in a room, sleeping in bunk-beds if they're lucky and on the floor if they're not. They have no protection from exploitation, abuse and capricious behaviour by landlords, the landlords' employees and sometimes complete strangers. Frail seniors lie bedridden and ignored.

Given that this is the situation, I think an awful lot of the concerns that have been expressed by some of the professional groups about how difficult it's going to be to put a Band-Aid on someone—we're a generation away at least from people finding the time, let alone the inclination, to worry about Band-Aids.

The situation today remains pretty awful for tens of thousands of us. So let's do it. Let's see this Advocacy Commission and let's revisit it in a year or two and maybe we can make some further changes, but for now, pass it. Thank you.

**The Chair:** Thank you very much.

CHEDOKE-McMASTER HOSPITALS/  
McMASTER UNIVERSITY  
RESEARCH ETHICS BOARD

**The Chair:** I'd like to call forward our next presenters, from the Chedoke-McMaster Research Ethics Board. Good afternoon.

Just a reminder you'll be allowed up to a half-hour for your presentation. The committee would appreciate it if you'd keep your remarks to about 15 minutes to allow time for questions and comments from each of the caucuses. As soon as you're comfortable, could you please identify yourself for the record and then proceed.

**Dr David Rosenbloom:** My name is David Rosenbloom. I come here this afternoon wearing several different hats. I'm a health professional; I'm a pharmacist, in fact. I'm a researcher; I do clinical research. As was stated, I am the chairman of the joint Chedoke-McMaster Hospitals/McMaster University Research Ethics Board in Hamilton.

Just before I begin I'd like to thank Lisa Freedman for directing me to do my homework for this presentation, as a result of which I can be mercifully brief because I will not repeat what's gone before in the previous weeks, having read the Hansards that have been produced as a result of the hearings here.

You've heard, in the first two weeks of hearings, excellent presentations by Dr Lowy, Professor Dickens, Drs Tucker, Schwartz and Tator from the University of Toronto, from Drs Greengarten, Stus and Conn from the Baycrest, from Dr Goldbloom from the Hospital for Sick Children and from Freeport Hospital and particularly from

Dr Borwein from the University of Western Ontario ethics committee and from Judith Miller for the National Council on Bioethics in Human Research. Their reports summarize everything I would have had to say about the role of research and the issues of consent and the issues of advocacy. They were very eloquently presented by those people.

One of the issues that's been brought up by people around this table is that research was not intended to be included in the legislation, and I acknowledge that this is the case. However, it may potentially be included as a result of the legislation in an unintended way. There are a number of possible things one could do to deal with that, because if it is included as part of the legislation, no matter how unintended, the problem is the research will come to a halt, and those vulnerable groups in the population who most need to benefit from the research being done—so I come here not with a criticism but with several constructive suggestions to make.

One suggestion is that you wait for the Weisstub report. The problem with that is that by the time it comes out it'll be too late to have amended this legislation, so I do not recommend that. Another suggestion that's been made around this table is to leave the legislation as written and to let the application of common law be used to determine the outcome with regard to research. The problem with that approach is that the application of common law could be vastly different depending on the interpretations of lawyers and judges, and it would also place the research ethics boards in jeopardy from the legal proceedings.

A third suggestion that was made by Dr Borwein is to amend or delete paragraph 15.1 of Bill 109, as well as various subsections: 47(6), 56(5) of Bill 108. This committee has discussed those possibilities.

1620

But I have a fourth suggestion, which is not an original idea of mine but one I first heard presented by Paul Wessinger. He gave the opening address at the Canadian Institute of Law Medicine, and in a forum entitled Health Science Research: Ethics, Law and the Role of the Public on June 11, this year, he suggested that legislation be developed to empower the research ethics boards to have the authority to sanction research, with the appropriate safeguards built in. The advantage of such an approach is that it overcomes the problems of application of different interpretations of common law. It addresses the needs of patients in the spirit of this present legislation and it provides a safeguard for the research ethics boards, which they may not have at present, to ensure that they are operating within the law. In other words, it's a win-win situation for everybody concerned.

You have experts capable of writing such legislation who have a knowledge of the law, of ethics and of health care, such as Gilbert Sharpe. My strongest recommendation is that you take this last option and advance the course of health care by empowering the research ethics boards in law to sanction research, with the appropriate safeguards, in the populations who, ironically, would be most penalized through inappropriate and unintended application of this present legislation.



**Mrs Sullivan:** Your presentation is short and your recommendation is one that I don't think has been before the committee before, in that it would provide greater responsibility in the public hospitals' ethics boards for determining the appropriateness of research, presumably on incapable people.

**Dr Rosenbloom:** Yes.

**Mrs Sullivan:** And would eliminate some problems which were made very clear to us by organizations such as the Alzheimer association. But in my view there are other associations where research efforts on incapable people may assist if not the people themselves who are incapable but the next generation.

What kinds of safeguards do you see as being guides for ethics committees in determining the parameters of research on incapable people? What areas do you think that they should be looking at?

**Dr Rosenbloom:** The present function of research ethics boards is, in fact, to protect patients, and I think that has to be made paramount. They are called ethics boards—unlike in the United States, where they are called institutional review boards—and the first thing they review is the methodology, because if the methodology is inappropriate, the research is not ethical and it should not be done.

The types of people on an ethics board allow many safeguards already. There are ethicists, there are people with content knowledge, people with methodological knowledge, there are laypeople, and, in fact, many ethics boards, such as ours, also have lawyers on them as well.

Should there be representation from our advocates for the type of individuals who are the vulnerable ones, in particular about research protocols? I frankly believe that ought to be discussed and debated, as opposed to my making a recommendation. I can see many positive reasons for including such people, but remember there already are laypeople on these boards. So the question of the need for duplication is there, and I think it's something that ought to be discussed in a broader forum.

**Mrs Sullivan:** There certainly have been medical ethicists and legal scholars who've looked at the nature of research that could be allowable on incapable people to include areas where the research would only be approved if there was minimal discomfort or other considerations with respect to the personal reaction of the patient. Is that something that you think can be codified?

**Dr Rosenbloom:** Yes, I do. In fact, I think that we do. We would take those considerations into account right now. We've been doing this all along. A lot of the issues are actually quite subtle, as I know you're aware from the comments that I've seen you make at the previous hearings.

For example, in a study to determine if children who don't grow at an appropriate rate should receive hormonal treatment that may help them grow, when one researcher suggested giving one intramuscular injection a day, one committee recommended no, give a constant infusion; it would be more acceptable.

The committee often goes even further in the direction of improving patient care than researchers feel the climate allows them to go. There are subtleties in terms of how the

researchers look at how they might be criticized when in fact they may do more harm by not going far enough to get at the answer that's most applicable to that patient.

The committee often agonizes over some of these decisions. The committees spend hours every month debating these issues. It might be an appropriate suggestion for those people involved with penning the legislation to actually attend some of those committees and look at what goes on and look at the safeguards.

**Mrs Sullivan:** This is an area of particular interest to me. Since we now have the counsel to the Ministry of Health with us, I would be interested in his moving to the table to talk about the potential of perhaps an amendment to the research section of Bill 109 that could provide for the kind of suggestion that is being presented in this presentation.

**Mr Gilbert Sharpe:** The notion of having protective legislation that would enable research on incompetent people and children to proceed with adequate protections is something that's been debated for a long time. About a dozen years ago, we worked on provisions that could respond to this concern. As we know, Professor Weisstub has been asked to study the issue, along with a number of other issues. It would be premature for me to guess at what he might be coming down with this fall. But certainly it's possible to structure legislation that would empower the research ethics boards to review protocols that involve research on incompetent people. Following certain safeguards and clear criteria such as a risk-benefit analysis, for example, one could establish a mechanism, perhaps with independent representation for the incompetent person and an appeal to court from their decision where warranted. So there are certainly a number of models that one could look at that might address the problem.

One of the concerns of the research community has been that there may be a case lurking around the corner similar to the Eve case regarding the sterilization form, which said that ultimately no one, including a guardian, could in common law consent on behalf of an incompetent person to a sterilization procedure in the absence of enabling legislation with adequate safeguards. Where a case like that comes through the courts on the research side, perhaps some of the research currently being approved on Alzheimer sufferers and others might have to stop. So there certainly are options available that could be examined. Again, I have to stress that I know the ministry has commissioned Professor Weisstub to advise on some of these issues, not just for research but for other non-therapeutic interventions on incompetent people as well.

**Mrs Sullivan:** Mr Chairman, you'll recall in the first round of hearings we were assured that the Weisstub report would be available to us before we concluded our discussion on Bill 109. Of course that is not available to us, so we don't have either recommendations on the research elements of the bill or on the assessment elements of these bills. It's a major weakness, because the consent elements are very clearly linked with research. I bet you any money we won't have anything on the table for years and I think that's a shame.

**Mr Sterling:** I don't have any questions. I understand what you're driving at and I think it's a very interesting approach.

**Mr Owens:** My comments are similar to those of Mr Sterling. Mrs Sullivan has probed the issue quite effectively.

I have a quick question: In terms of legislative language, do you feel the language should be narrow in terms of describing the types of research that could go on? My concern is that we've heard evidence during the hearings that aversion therapy is still ongoing in this province and I certainly wouldn't want to have research being performed on incapable people with respect to some of the tools that are used in aversion therapy. However, I would be interested in seeing ongoing research, for instance, into neuroleptics which perhaps wouldn't have the kinds of side-effects the current products have. So my question is, would you like to see a broad scope of language or would you favour a narrow, more defined process?

**Dr Rosenbloom:** Actually, I would like to see a broad scope of language. It's my firmly held belief that patients

will do much better if they're in a research protocol than if they're under routine care, because the quality control of the care that's given to them on a research project is much more intense: They're seen more often and they're looked at more closely for adverse effects. Neuroleptics may develop adverse effects that, if you're not looking closely for them, will go unnoticed, which is why it's often a shock when a drug is withdrawn, because people have not been looking for those adverse effects. On research protocols those patients are looked at more closely. One won't know if they develop adverse effects unless one does research, so narrowing it could be more harmful, in fact.

**The Chair:** Mr Rosenbloom, on behalf of this committee, I'd like to thank you for taking the time today to give us your presentation.

Seeing no further business before this committee, unless we hear otherwise from the House leaders, this committee stands adjourned until August 31.

The committee adjourned at 1633.



**Also taking part / Autres participants et participantes:**

Auski, Jutta, senior consultant, policy development branch, Ministry of Health

Callahan, Robert V. (Brampton South/-Sud L)

Lafrenière-Davis, Nicole, director, children's services branch, Ministry of Community and Social Services

Malkowski, Gary, parliamentary assistant to the Minister of Citizenship

Martin, Heather, policy analyst, children's services branch, Ministry of Community and Social Services

Sharpe, Gilbert, director, legal services branch, Ministry of Health

Valentine, Mary Beth, senior policy and program adviser, Office of Disability Issues, Ministry of Citizenship

White, Drummond (Durham Centre ND)

**Clerk / Greffière:** Freedman, Lisa

**Staff / Personnel:**

Gardner, Dr Bob, assistant director, Legislative Research Service

Swift, Susan, research officer, Legislative Research Service











## CONTENTS

Thursday 13 August 1992

<b>Advocacy Act, 1992, and companion legislation</b> . . . . .	J-237
Ontario Medical Association . . . . .	J-237
Dr Ted Boadway, director, health policy	
Barb LeBlanc, manager, health policy	
Dr Ian Warrack, board chair	
Ontario Association of Developmental Service Workers . . . . .	J-244
George Anand, president	
Easter Seal Parent Advocacy Committee . . . . .	J-246
Ludmilla A. Donald, chair	
Canadian Association for Community Living . . . . .	J-251
Kenneth Pike, member, task force on alternatives to guardianship	
Diane Richler, executive vice-president	
Canadian Diabetes Association, Ontario division . . . . .	J-257
Peter Harvey, chairperson, social issues committee; member, national advocacy council, CDA	
Advocates' Society . . . . .	J-260
Ray Colautti, director	
Eleanore Cronk, president	
Ontario Association of Non-Profit Homes and Services for Seniors . . . . .	J-269
Paul O'Krafka, president	
Michael Klejman, executive director	
Canadian Mental Health Association, Ontario division . . . . .	J-271
Hugh Tapping, chair, policy advisory committee and board member	
Carol Roup, senior director of policy, research and branch services	
Chedoke-McMaster Hospitals/McMaster University Research Ethics Board . . . . .	J-275
Dr David Rosenbloom, chairman	

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

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- \***Vice-Chair / Vice-Président:** Morrow, Mark (Wentworth East/-Est ND)
- \*Akande, Zanana L. (St Andrew-St Patrick ND)
- \*Carter, Jenny (Peterborough ND)
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- \*Malkowski, Gary (York East/-Est ND)
- Runciman, Robert W. (Leeds-Grenville PC)
- Wessenger, Paul (Simcoe Centre ND)
- \*Winninger, David (London South/-Sud ND)

### **Substitutions / Membres remplaçants:**

- \*Cordiano, Joseph (Lawrence L) for Mr Mahoney
- \*Owens, Stephen (Scarborough Centre ND) for Mr Wessenger
- \*Sterling, Norman W. (Carleton PC) for Mr Harnick
- \*Sullivan, Barbara (Halton Centre L) for Mr Chiarelli
- \*White, Drummond (Durham Centre ND) for Ms Carter
- \*Wilson, Jim (Simcoe West/-Ouest PC) for Mr Runciman

\*In attendance / présents

*Continued overleaf*



## Legislative Assembly of Ontario

Second session, 35th Parliament

# Official Report of Debates (Hansard)

Monday 31 August 1992

## Standing committee on administration of justice

Advocacy Act, 1992

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

# Journal des débats (Hansard)

Lundi 31 août 1992

## Comité permanent de l'administration de la justice

Loi de 1992 sur l'intervention



Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
Greffière : Lisa Freedman





### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

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### **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Monday 31 August 1992

The committee met at 1354 in committee room 1.

### ADVOCACY ACT, 1992

### LOI DE 1992 SUR L'INTERVENTION

Consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervention en faveur des personnes vulnérables.

**The Chair (Mr Mike Cooper):** I would like to call this meeting of the standing committee on administration of justice to order.

I would like to remind all members of the relevant provisions of the subcommittee report and order of the House under which we are operating. The committee will utilize the reprinted bills containing proposed government amendments and deem these amendments moved. A maximum of two days' clause-by-clause consideration shall be spent on each of the bills, except for Bill 110, which shall be considered for no more than one day. Votes on the individual sections of the bills and on the bills as a whole shall be deferred until following consideration of the final bill.

It is my understanding that given the unique situation that we face, considering four interrelated bills at the same time, it was the intention of the subcommittee to ensure that the bills would be amendable right up until the last moment. If, for example, an amendment was to be made to Bill 110 that affects the other bills, the subcommittee wanted to ensure that there would be an opportunity to go back and amend the other bills so that there would be consistency.

With this in mind, and given that the standing orders on deferred votes in the House do not easily translate to committee practice and given that it is the responsibility of the Chair to ensure the orderly progression of committee business, I would like to outline the following rules to guide us in our deliberations. Given that this is the first that I know of that any committee has attempted to deal with such a complex process, I am not intending that the following guidelines become firm committee precedents, although at the conclusion of the process, the Chair would invite feedback on the pros and cons of the process.

1. If there are no amendments before me to the section under consideration, I will simply ask if there are any questions, comments or amendments. If there are none, we will defer the vote on the section and proceed to the next section.

2. If there are amendments to the section under consideration, either incorporated in the reprint or yet to be moved, I will proceed through the individual clauses of the section and ask for questions, comments or amendments to each clause. Any amendments that have yet to be moved shall be moved at that time. If the clerk is not in previous possession of an amendment that you wish to move, please

provide the clerk with 25 copies of the amendment at the time you move the amendment. If an amendment already appears in the reprint, the government will be given an opportunity to explain the amendment if it so chooses, then the opposition parties will be given an opportunity to either comment on or ask questions about the amendments. As we proceed through each amendment, we will vote on the specific amendment. What will be deferred are the votes on the sections as a whole. By deferring the votes on the sections, members will, subject to the order of the House, be permitted to revisit a section without unanimous consent.

Some may ask why we are not deferring all votes, including votes on amendments, and the answer is quite simple: Without knowing what amendments have either passed or been defeated, it may be difficult for some members to know what further amendments to move or how to vote on a subsequent section. Should members wish to revisit an amendment that has already been either passed or defeated, unanimous consent would be required. Should unanimous consent not be forthcoming, members may always revisit an amendment during committee of the whole consideration.

3. Pursuant to the order of the House dated 28 May 1992, all proposed amendments shall be filed with the clerk of the committee by 4 pm on the day prior to the last day on which the committee is authorized to consider the bills clause by clause, that is, by 4 pm on 15 September 1992. At 4 pm on the last day, 16 September, those amendments which have not been moved shall be deemed to have been moved, and I shall interrupt the proceedings and shall, without further debate or amendment, put every question necessary to dispose of the amendments and the bills. Given that the rules of the House on deferred votes do not equate to committees in this context, I will at the time of the vote entertain no more than one standing order 126 request for up to a 20-minute recess per bill for the purpose of bringing in members for the vote.

4. Should we conclude our deliberation on a bill prior to the expiration of the time limit for that bill, I will entertain an adjournment motion to the next day. We will not proceed to the next bill for the simple reason that we may not be in possession of all amendments and we may not have the appropriate ministry personnel in attendance.

I think that all members are in agreement that there is a desire to allow the fullest debate on all amendments, and the Chair will endeavour to conduct the committee proceedings to achieve this objective.

It is also my understanding that members have informally agreed to one five-minute opening statement per caucus at the beginning of the consideration of the first bill. We will begin with the government, then the official opposition and then the third party.



In addition to this, we have reached agreement that being as we've just received all the opposition motions for amendments, we won't be voting on any amendments today. We will have them deferred till tomorrow so that the ministry people have a chance to look them over tonight, because it's my understanding that none of these amendments are frivolous, and they shouldn't be taken lightly.

So if we could, can we have an opening statement from the government?

**Mr Gary Malkowski (York East):** Thank you very much, Mr Chair. It's my great honour and pleasure to be able to make an opening statement here for the Minister of Citizenship, Elaine Ziemba, on behalf of the government. I think that this is a critical and very important occasion to be able to open this debate on the Advocacy Act, Bill 74, and the amendments pertaining to that.

At this point, it's important that we remember those individuals who will be directly affected, those vulnerable individuals who for the last 20 years have not had their concerns addressed. I'm sure that the rights, respects and wishes of those individuals are something that we all want to make sure are taken into consideration.

We also have to consider the family members and care givers who also have brought concerns to us in regard to the protection of vulnerable individuals in hopes that they will in fact be protected against neglect and risk or abuse of any form. It's important that we do provide these people with the opportunity to live an autonomous, independent life with dignity in a free fashion as much as possible in society. I think our agenda is definitely to make sure that this legislation becomes a reality.

1400

I want to thank the previous governments, both the Liberal and Progressive Conservative governments, which began work on this issue and have worked towards helping vulnerable individuals attain autonomy and freedom of choice and respect and dignity in society. We're here today to continue to listen to the Progressive Conservative and Liberal members, as well as the government members, as we discuss important amendments.

I know that my minister is anxious to hear from the opposition parties on possible amendments and ideas to make sure that in fact we are able to work together. I think that our goal is definitely to work in cooperation as a means of providing the best type of policy and legislation in a democratic fashion that will in fact respect the rights and needs of vulnerable individuals and to make sure that equity actually does occur.

In saying so, I also again want to say that it's important that we not only protect the rights of vulnerable individuals, but we consider the needs of family members and care givers. It's important that we offer support to people to make sure that autonomy actually does occur. I'm very proud to see that our government has established this legislation and that the Advocacy Act is in fact moving forward. We look forward to seeing this legislation in place.

I encourage all of the members, government members and opposition members, to remember that we should be working together in order to have successful legislation

that will benefit those most vulnerable individuals in society, people who have in fact been struggling to find autonomy and to have their needs met.

At this point also, I'd like to remember Father O'Sullivan and the report that he wrote that talked again about the incredible need to have legislation in place to be able to protect vulnerable individuals from abuse and neglect in society. Those are some critical guidelines that we, I think, must follow.

In closing, I would like to again say that it's important that we also see ourselves as friends of vulnerable individuals and work together to that end and that during these discussions and debate on amendments, we do work cooperatively and listen to each other in order to produce the best legislation possible. We definitely have to consider ourselves friends of the people we hope to protect.

**The Chair:** For the official opposition, Mrs Sullivan, your opening statement.

**Mrs Barbara Sullivan (Halton Centre):** Thank you, Mr Chairman. I'm not sure if I will go over the five minutes or under the five minutes, but I hope you will indulge me if I am slightly over time.

For several months, we have been considering the four bills, Bills 74, 108, 109 and 110, which are all interconnected and intensely interrelated. Furthermore, those bills have enormous implications for every individual and family in Ontario. Further than that, every health care practitioner and institution will be affected. Many educational settings, social service agencies and community organizations will have to work with new rules and new parameters.

What is deeply disturbing to me is the lack of care and attention that the government has paid to these bills. Ministers have not shown up other than to make opening statements that were clearly written by others, and in the few questions that they deigned to answer, it was evident that they had little knowledge of the policy or implementation implications of these bills. To my mind, this is a grave dereliction of duty on the part of the Minister of Citizenship, who had the lead on these bills, and her colleagues the Minister of Health and the Attorney General.

To say that both policy thought and drafting have been negligent is evidenced by the 199 amendments which were brought forward by the government. Were it not for our insistence that new public hearings be held, there would not have been the benefit of knowing that even with those amendments, there were serious flaws, indeed dangerous flaws, in these pieces of legislation.

I want to speak personally for a second. I worked very hard on these bills, and there were several reasons for that. First of all, I'm critic for the Ministry of Health, and the public policy implications of codifying the consent to treatment laws are singularly important in that field. As an individual and a politician and a legislator, I am eager and supportive of measures that will protect people who can't protect themselves and to encourage the expression of will of those who most people don't believe or haven't even thought about having will.

Given the government's policy determination, I believe it was important to ensure that the legislation I as a legislator



was a part of formulating was useful, was practical, and enhanced rather than negated the quality of people's lives. My colleagues in my party and in the opposition in the third party have also put extra effort, it seems to me, into the consideration of these bills for the same reasons.

In the course of the legislative process, I've been panic-stricken at times. If we think back to the first round of hearings, we will recall some of the stressful situations which were raised before this committee.

I saw that people who were injured or in pain perhaps could not have timely access to medical treatment. I saw that people who were not able to cope with some things might be judged as not able to cope with all things. I saw that the balance of rights was being skewed.

I saw a burgeoning bureaucracy, at enormous public cost, with little accountability. I saw families being put into an adversarial position, with new processes and intervenors adding new stresses, costs and fear. I saw doctors, dentists, nurses, hospitals, nursing homes, people who teach vocational courses and many others being seen as enemies. I saw a broad-reaching legislative focus that captured every resident of Ontario perhaps, instead of those who most needed help.

Assuredly, the government has made changes, but those changes only came when people by the score appeared before this committee, at enormous cost of time and money, to say that what had been put forward was unworkable, that it hadn't been thought out, that the implications hadn't been explored. Those people knew this committee was working under an artificial time frame imposed by the government that is nothing less, to my mind, than irresponsible.

Many of the people who came before us apologized that they weren't able to afford legal counsel to assist them with their analysis of the legislation, and many of them engaged counsel in lengthy and costly scrutiny of the provisions of these bills.

In my time in this House, I don't remember an effort that was so assiduous, so demanding, so well documented and so well prepared by people and organizations. I want to commend everyone who was a part of the public process that we've been involved in, but I can honestly say that I'm personally embarrassed by the government incompetence that has been shown throughout these proceedings.

The government, however, is clearly determined to move ahead. To suggest that these bills, with myriads of amendments from government in the first instance and from opposition party representatives in the second, can be dealt with in clause-by-clause committee review in seven working days is ludicrous, but those are the constraints that have been put on us by the government.

I sincerely don't believe that the government has any notion of the depth of concern and unease that accompanies these initiatives. Too many things are unknown, despite the complexity of the legislation. We don't know when a person has to give consent to medical treatment or to what kinds of medical treatment. We don't understand why, by example, a physician would require the consent of a patient to do a pelvic examination in a hospital, perhaps, but that physician may not require the consent of a patient to do a pelvic examination in the physician's office.

We don't know what an advocate can or can't do by law. We don't understand why, when the government is establishing a new profession, it can't define the scope of activity, the training, the code of ethics and the standards that will apply to people in that profession, who will have highly interventionist roles in other people's lives.

We don't know if the government will require hospitals and nursing homes and other institutions to provide round-the-clock rights advisers at their own expense and without expanded government funding. We don't understand how that requirement will square with the government's head-nodding at the independence of the advocate from the provision of services. We don't know the qualifications of an assessor who will decide if a person is mentally capable of making various decisions. We don't understand if the government intends that they should be medical practitioners only or if they could be social workers, lawyers, teachers, dentists or nurses. Most of all, we don't understand why the government is in such a rush.

#### 1410

Surely, we all need time for a considered analysis of the proposals in these bills. We all need time to review more thoroughly how they will affect the average 16-year-old, the average 40-year-old and the average 70-year-old, and we certainly need time to review how they will affect the person who isn't average. We also need time to learn how they will affect families, hospitals, doctors, nurses, midwives and group homes and many others.

Groups, organizations, agencies and individuals are calling on the government to slow down the process, to exercise caution in drafting regulations and to involve all the stakeholders in that process. I couldn't underline more how much I agree with those who are making those demands. Time, thought and scrutiny are needed. One leap forward in the case of these bills, I fear, could in many cases be a giant leap backwards.

We will be presenting many amendments to the bills in the course of clause-by-clause consideration. None of those amendments is frivolous. All of them have been discussed with stakeholders and honed according to their advice. Some recommendations which we would have liked to put forward have not been included as amendments, because there was inadequate time and discussion of the implications of those initiatives. Medical research issues, by example, are inadequately covered under these bills, but were not thoroughly explored in the time we had available either in public hearings or in prior and later consultative sessions.

As well, other issues that have been before us have not been satisfactorily resolved. We've heard from people who deliver health care services to young adults and children, and they've stressed to us that in certain circumstances it's vital to allow a young person to seek independent and private medical advice and counsel in a number of areas. We've also heard from children's aid societies and youth workers that age issues are integral to their statutory mandates and service delivery requirements.

We can see that the government has introduced rights advisers in all cases where children are more than 12 years of age if the child is considered incapable of providing consent to a treatment. As a committee we asked, with



all-party agreement, for a full statement from counsel for the government with respect to the matter of age. The government has withheld that analysis from us.

As a committee we asked, with all-party agreement, that the ministers who are responsible for this legislation sit in clause-by-clause consideration. The ministers say they're too busy; they're going to a retreat.

If I sound angry about those two issues in particular, it's because I am angry. If we're to do our job as legislators, we're entitled to the information we require, when we require it. If I sound cynical, it's because I am cynical. I personally don't believe that the Minister of Citizenship or the Minister of Health or the Attorney General have any idea what is in these bills, nor what the implications of these bills are, nor what disruptions will be caused by their implementation, nor what the costs are to governments, to agencies, to health care facilities and to individuals.

I further don't believe that the ministers understand the import of a consultative process with stakeholders in relationship to the formation of the regulations under the act. If I sound surprised, well, I suppose, why should I be? The ministers have paid very little attention to this legislation all along.

**The Chair:** Thank you, Mrs Sullivan. Opening statements for the third party.

**Mr Norman W. Sterling (Carleton):** I had understood that we were going to have an opportunity to say a few words on each bill, and therefore have really only prepared myself with regard to Bill 74, the one we're dealing with today.

I'd first of all like to thank Susan Swift of the committee, who has put a lot of effort into giving us a summary of the various presentations which have been put forward by a whole number of groups. Lisa Freedman has done an excellent job in coordinating witnesses, and we have been able as a committee to say to most groups, "You've had the opportunity to be heard." I'd also like to thank Laura Hopkins for her help in drafting some of our amendments as legislative counsel.

Secondly, I'd like to thank the many groups that came in front of us, because this and the other bills cover very substantial issues, very important issues, critical issues to vulnerable people and to our health care providers in particular.

I found that almost universally the groups had prepared themselves well, knew what the bills said, and were very much concerned with the contents of those bills. I only wish the ministers of the various ministries who were responsible for these bills exhibited the same kind of knowledge and the same kind of feeling towards these bills.

Unfortunately, when we opened these hearings back in the early spring, the Martel affair was occupying the news media at that time. I think it's unfortunate for the people of Ontario not to be alarmed about what these bills might or might not do to their future health care and the future intrusions that these bills bring forward.

We have, as a party, tried to be as constructive as possible in dealing with these bills. We have agreed to scheduling these hearings. We have agreed to scheduling

the third reading debate and the committee of the whole House after this bill returns to the Legislature. We agreed to the timing, unfortunately, before hearing a lot of the public hearings during this past summer. I do not know whether it is really prudent for the government at this time to continue on that timetable. We will have to do that because we have given our word and, of course, it's included in terms of the timing of the motion and is locked in at this point.

I only say to the government that it might be very wise to go to the opposition House leaders and ask for more time, considering the hearings we had this summer and the very many concerns with regard to this legislation during that period.

We continue to be concerned over the cost of the Advocacy Commission. We're concerned because the \$30 million that has been estimated to put the commission together does not provide for vulnerable people in this province one more bed, one more meal or one more treatment to alleviate pain or distress to that vulnerable person. In other words, we are not convinced even at this point that the Advocacy Commission is going to improve the lives of vulnerable people as much as if we took that \$30 million and put it into social or health care services which these people so desperately need, as was given in evidence before this committee.

We also have concerns at this stage of our hearings with regard to the Advocacy Commission and its appearance as a very intrusive force into both the private lives of the people of Ontario and into our public lives as the people of Ontario. We are concerned over the extreme powers that an advocate possesses under this act to influence an incapable or a vulnerable person, even if that vulnerable person is perhaps not requiring those services or wanting those services.

We are concerned that the Advocacy Act says to our people who provide our health care services, who provide our social care services, "We don't trust you; we need these people looking over your shoulder," when there hasn't been any kind of overwhelming evidence that our public servants, our health care providers, are in any way on a consistent basis or even on a minimal basis abusing vulnerable people.

We are concerned over the lack of thought as to what an advocate really is to be. We do not know yet what educational qualifications are needed to be an advocate and, above all, we don't know what kind of controls or code of ethics the advocates are going to operate on. We do know that this commission, as set up under Bill 74, is indeed going to be a very powerful body which is, in essence it seems, accountable to no one.

We are also very much concerned about the intrusion of the advocate into the family unit and the friends of a vulnerable person. We are very concerned that with the Advocacy Act, because of these lack of definitions of what an advocate is to be and who controls that advocate and the total lack of a discipline process within this act, the potential for conflict between the families and friends of the vulnerable person is great and almost inevitable.

Last, I must echo some of the sentiments of Ms Sullivan with regard to her concern over the feeling, as an opposition member, of the competency of the government in putting the pieces to this very difficult puzzle together.

I have not felt, as an opposition member, during these hearings that there is a concerted effort on the part of the ministers of this government, who are responsible for Bill 74, who are responsible for Bills 108, 109 and 110, to have their act together. I am not confident that they have thought through what these acts are going to do for the ultimate—and which we, as politicians, all must have—better treatment of our vulnerable people or the people who cannot make decisions on their own.

I think this act is being driven or it appears to be driven from outside. It appears to be driven by a subjective goal rather than an objective goal. I believe the government of Ontario should be trying to reach a conclusion in bringing forward legislation in this area, if it so chooses, in a balanced and even manner which will in fact bring better treatment to our vulnerable people.

We will continue to act in a constructive manner as best we can. Although we have great concerns about Bill 74, we have put a fair amount of time—in fact, a great deal of time—in putting forward amendments to this bill in order to try to remedy it as best we can, even though we will probably remain opposed to it even in an amended form. But that will be for us to decide at a later date, after the amendments have either been received or rejected.

Mr Chairman, thank you for your patience. As well, I want to commend you with regard to your impartiality to date with regard to dealing with these bills.

**The Chair:** Thank you, Mr Sterling. Thank you, all members, for your opening comments. In fairness to the clerk, until we can get everything organized, this committee will stand recessed for five minutes.

The committee recessed at 1424.

1447

**The Chair:** I call this meeting back to order. All members now have, basically, what we call a road map to follow as we go along. The “GR” is government reprint, which means it doesn’t have to be moved; “GA” is a government amendment, which will have to be moved by the government; “L” and “PC” are self-explanatory and they will have to be moved.

With the indulgence of the committee members, to save time, the Chair will not repeat motions, because this is going to be fairly lengthy. Perhaps we could get started.

**Mrs Sullivan:** Mr Chairman, I don’t think we have copies of the newest government amendments.

**The Chair:** You should. There were three or four.

**Mrs Sullivan:** I have three, but I understand there are more.

**The Chair:** There was a package sent to all committee members’ offices on Friday.

**Mrs Sullivan:** Oh, so we don’t have another clean copy of them.

**The Chair:** No, we don’t.

**Mrs Sullivan:** Okay.

Section 1:

**The Chair:** If we could, on Bill 74, clause 1(a), any questions or comments?

**Mrs Sullivan:** Just a clarification as to process: By example, the first amendment put forward by the government, which is printed in the bill, refers to a whole clause, whereas the second amendment put forth by the opposition refers to a subclause of the same clause. What will be the process of dealing with that? I understand that today we’re just discussing them, but I’m just wondering how that process will work.

**The Chair:** The motion will have to be moved at that time. When we go to clause 1(b), you can move your motion then.

**Mrs Sullivan:** When we vote, if, by example, we are voting on 1(b), how do we deal with 1(b)(ii), which is the second amendment?

**The Chair:** We’ll let the clerk go with this one.

**Clerk of the Committee (Ms Lisa Freedman):** Essentially what would happen is the government reprint 1(b) would be moved first, and it appears in the reprint. Clause 1(b)(ii) is an amendment to that amendment. It gets moved second but debated first. First of all, you need what’s in the section. Your amendment has been drafted in a such a way to amend what they originally had, so that appears as an amendment to the amendment. Yours would be voted on first, because if yours passes, theirs would then subsequently incorporate that amendment.

**Mrs Sullivan:** If the government has a new amendment that is before us today, not the ones that have been reprinted, and there’s a similar situation, how will that be dealt with?

**Clerk of the Committee:** I think the way we have this road map we’ve tried to incorporate that. If we hit that situation in a section, we will deal with the broad motion first, and any amendment that amends something within the broad motion would be an amendment to that amendment and would be moved second but debated first.

**Mrs Sullivan:** Thank you.

**The Chair:** Questions or comments on clause 1(a)?

**Mrs Sullivan:** I have nothing on 1(a).

**The Chair:** Clause 1(b)?

**Mrs Sullivan:** I just want to confirm with the clerk that in 1(b)(ii) of the government amendments there’s a misprint and that it will be corrected.

**The Chair:** It will be corrected editorially.

**Mrs Sullivan:** Fine.

**The Chair:** Would you care to move your motion?

**Mrs Sullivan:** Should I move now, or just discuss?

**The Chair:** Move it, and then we’ll defer the vote till tomorrow.

Mrs Sullivan moves that subclause 1(b)(ii) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

“(ii) to help individual vulnerable persons who are incapable of instructing an advocate, if there are reasonable



grounds to believe that there is a risk of serious harm to the health or safety of those persons, and.”

**The Chair:** Comments, discussion?

**Mrs Sullivan:** Yes. Basically, this is really a drafting amendment to ensure consistency with other sections of the bill which require the advocate to act on the reasonable grounds of harm to the health or safety of those persons.

**The Chair:** Further questions, comments?

**Mr Sterling:** We agree. For consistency, it probably makes sense.

**The Chair:** Thank you. Seeing no further questions or comments, clause 1(c). Questions or comments? Clause 1(d)? Clause 1(e)? Clause 1(f)?

Mrs Sullivan moves that clause 1(f) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out “support for the security” in the third line and substituting “support for the rights, needs, security and wellbeing.”

**Mrs Sullivan:** This recommendation was put before us, particularly by the Ontario Friends of Schizophrenics, to ensure that the support of willing and able friends and family is, in the area of ensuring the rights and satisfying the needs of vulnerable persons, accorded the same responsibility as the work of the advocate. The addition of rights, needs, and wellbeing into that section enables the family to serve as advocates to the full extent of the person’s requirement.

**The Chair:** Thank you. Mr Wilson.

**Mr Jim Wilson (Simcoe West):** Yes, Mr Chairman. We have agreement on this Liberal amendment also, and it might be helpful if the government members would comment as we go along; then we’d know where we stand in the voting tomorrow. I want to know how long I have to stay out in the lobby.

**The Chair:** Comments? Mr Winninger.

**Mr David Winninger (London South):** If you want to go back for a moment to subclause 1(b)(ii), it seems to me that inserting the phrase “reasonable grounds” provides for a “reasonable person” test, and I don’t see anything objectionable about that. It might prevent people from making subjective assessments. They would be required to invoke a reasonable person test, and the latter amendment, from my point of view, is certainly a desirable one because it expands a little on the original wording of clause 1(f) and certainly accedes to the request of one of the presenters.

Section 2:

**The Chair:** Mrs Sullivan moves that the definition of “vulnerable person” in section 2 of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

“‘vulnerable person’ means a person who, because of a moderate to severe mental or physical disability, illness or infirmity, whether temporary or permanent,

“(a) is unable to express or act on his or her wishes or to ascertain or exercise his or her rights, or has difficulty in expressing or acting on his or her wishes or in ascertaining or exercising his or her rights,

“(b) does not have another person who is appropriate, able and willing to assist him or her in exercising his or her

rights, in expressing or acting on his or her wishes or in ascertaining or exercising his or her rights, and

“(c) is in a position in which there is a risk of serious harm to his or her health or safety.”

**Mrs Sullivan:** The amendment that’s proposed is designed to ensure that those people who are most vulnerable are the people who receive the advocacy services that the bill provides for. It eliminates the assumption that any person who is disabled is vulnerable or has no assistance or has made no determinations, by example, about the kinds of assistance that that person wants.

It includes, by inference, families, the friends—the power of attorney or the guardian who is able to work with the person and assist in obtaining rights and in ascertaining those rights. I think that strengthens the role of the advocate to deal with the person in our society who is most vulnerable.

1500

**The Chair:** Thank you. Further comments, questions? There is one mistake on the road map. Mr Sterling.

**Mr Sterling:** We have some support for this. We also have our own amendment there with regard to “vulnerable person.” I’d like to hear how the government reacts to either of them.

**Mr Malkowski:** At this point I just have to clarify that at times, if I have looked down just to take a look at the motion, I am unable to attend to what the interpreter said. So I missed what you said, Mr Sterling. Could you just repeat that last comment? I was looking at my page at the time.

**Mr Sterling:** I’d like to put forward sort of on the table both amendments, the one we’re putting forward and considering the Liberal one, and see what the government’s reaction is to either.

**The Chair:** Would you like to move your amendment first, Mr Sterling?

**Mr Sterling:** Have you finished, Barbara?

**Mrs Sullivan:** I’ve finished with my motion and my discussion, so I guess it’s in order.

**The Chair:** If you would move your motions, Mr Sterling, then we could discuss them all together.

**Mr Sterling:** Okay. The first amendment I put forward—and I’m not moving it—was just for the sake of clarity.

I move that the definition of “vulnerable person,” as set out in paragraph 5 of section 2 of the bill, be amended by deleting the words “moderate to severe.” I wanted to elongate that, so if the committee will bear with me, I’m going to add some words to the end of that.

**The Chair:** Mr Sterling moves that the definition of “vulnerable person,” as set out in paragraph 5 of section 2 of the bill, be amended by deleting the words “moderate to severe” and substituting therefor the word “substantial.”

Would you like to explain that?

**Mr Sterling:** Yes. Basically, I believe it’s a better definition. If we are going to have an Advocacy Commission, I don’t know what “moderate to severe” means. It seems to

cover every perceived kind of disability that a person might have, and in my view, regardless of how much it has, the commission is always going to be limited in the amount of money it has. Therefore, I would like them to give priority to those people who have a greater disability than those with a lesser disability. So it will allow, in my view, then the opportunity to make that prioritization in giving services.

**Mr Malkowski:** There are two points or comments I'd like to make in relation to that motion. First, in terms of the terminology "moderate to severe," that term has been recognized by the federal government and Statistics Canada and, as you know, the Ontario Human Rights Code, the amendment explaining the definition of vulnerable people when looking at the perception of actually having a disability, infirmity or illness or the perception that someone has a disability, whether or not it can actually result in the individual's having specific difficulties with the exercising of his own rights.

**Mr Sterling:** Mr Chairman, I don't feel very strongly about this amendment, so I'll withdraw it.

The second amendment I have is on the same section, on the next page.

**The Chair:** Mr Sterling moves that the definition of "vulnerable person" as set out in paragraph 5 of section 2 of the bill be amended by deleting the words "and whether actual or perceived."

**Mr Sterling:** During the hearings, I asked counsel why these words were added, as I believe they were added when the government brought forward its amendments to this bill. Again, it is somewhat the efficiency argument, that the Advocacy Commission or an advocate should be chasing real problems and not perceived problems and that they should be able to distinguish between the two. I heard the argument that this was some kind of United Nations definition, and I don't think that makes much sense when dealing with real problems of real vulnerable people.

**Mr Malkowski:** To respond to that, the Ontario Human Rights Code has a very clear definition of what a vulnerable individual is and does include that definition.

**Mrs Sullivan:** I want to say that our party concurs with this motion; indeed, it is integrated into the motion I put forward under section 2.

**Mr Paul Wessinger (Simcoe Centre):** I would like to make some comments about eliminating "and whether actual or perceived." Mr Sterling, I don't know whether you were here, but we had before us People First, who indicated the necessity for that language, that the people who are developmentally handicapped are often perceived as being unable; that it isn't an actual disability, but a perception of the people who will not listen etc as a result of their perception of the person having an inability. So they felt it was very important that the words "and whether actual or perceived" remain. It seemed quite a compelling argument that they put forward, so I thought I should indicate that.

The other aspect I have some concern about—I don't know whether I should speak to the Liberal amendment at this time—is clause 2(c) that adds, in the definition of "vulnerable," the risk of serious harm. It would seem that

the risk of serious harm would be the test for intervention rather than the test for defining who a vulnerable person is. Surely a person is vulnerable whether there's a risk or not, so from a legal point of view, I don't think it's appropriate to have that incorporated in the definition of "vulnerable."

**Mr Winninger:** I share Mr Wessinger's concern about deleting the phrase "actual or perceived." There may be situations such as the notable one involving Justin Clark where, through inability to communicate, the vulnerability was perceived rather than actually expressed.

Another concern I have about Ms Sullivan's amendment relates to clause 2(b). The first phrase, "does not have another person who is appropriate," is certainly an addition to our definition, and I'm not so sure that doesn't severely limit access for vulnerable people. There may be other people in their universe who are appropriate, who may be able and perhaps willing to assist, but that shouldn't exclude that person from the category of vulnerable.

A third concern is clause 2(c), which places a fairly high test for vulnerability; it suggests there has to be a risk of serious harm to his or her health or safety. Through the presenters, we've heard of many more marginal cases of vulnerability that certainly wouldn't meet that test, and these people would likely go unprotected if this machinery in our legislation weren't invoked because they weren't defined to be vulnerable.

Perhaps we'll hear from other government members, but my desire would be to have this section stood down for further consideration by the ministries.

1510

**Mr Sterling:** What was your first objection?

**Mr Winninger:** The first related to the phrase "actual or perceived." I think it's a more embracing definition of vulnerability than were it just to say "actual infirmity or disability or illness."

**Mr Sterling:** So if "actual or perceived" were put into Mrs Sullivan's, and (c) were out—

**Mr Winninger:** I would still have a problem with (b), which requires that there not be another person who is appropriate, able and willing to assist."

**Mr Jim Wilson:** I have a question dealing with (b) also. Perhaps legal counsel can give us an opinion on whether it's appropriate to put that. I understand and appreciate what Mrs Sullivan is doing here in trying to protect the role of family members, as an example, but I just wonder if it's appropriate in a definition when other parts of the bill deal with who is an appropriate person.

**Ms Jenny Carter (Peterborough):** I'd like to say that I think (b) and (c) are ill advised, because they do in fact limit the applicability of the act, as has already been said. The point is that we're looking at satisfying the wishes of the vulnerable person, and although there might be an outside perception that there's somebody else who is assisting that person, if he or she doesn't feel they are helping to interpret his or her wishes, then that should not be set up as a barrier.

Similarly, the problem they have may not be sufficiently serious to qualify under (c), and yet that should not be a



reason why they can't in fact have their wishes attended to. It might be about something that appears relatively trivial but actually does matter a great deal to that person. So we don't want those kinds of limits put on the act.

**Mrs Sullivan:** I wonder if I could have a further understanding of the actual policy objection to (b). What we are looking at, in the case of including that clause, is a person who is unable to express or has difficulty in expressing his or her wishes, is unable to ascertain or has difficulty in ascertaining his or her rights, is unable to exercise or has difficulty in exercising his or her rights. That same qualification applies to all people I'm now describing as vulnerable.

If a person is alone in that situation, surely that is the time when the advocate is most needed and when the advocate should be involved in intervention. If a person has a parent who is working as a personal advocate, if a person has a power of attorney for personal care—and that person has in fact provided the consent and the direction in terms of setting up that power of attorney—if that person is incapable under the Consent to Treatment Act or the Substitute Decisions Act and for other reasons has a guardian or a partial guardianship in particular, that person has someone who meets those qualifications and who is able and willing to help that person exercise his or her rights and express the wishes, ascertain those rights.

In fact, in those situations, I think the important words are "to assist." We've had many discussions about supportive decision-making. Indeed, that is what that section is about. There's also an implication of the determination of the person himself or herself in deciding who it is who is available, willing, able and appropriate to assist that person in exercising those rights and determining those rights.

I do not understand the policy objections from the government members as they've been expressed, when what we're looking for here is a definition of who in our society really needs help to determine those rights, to exercise those rights, to achieve access in various places, in various ways. It seems to me that this is the place where we should be starting.

I hear Mr Wessinger's point with respect to clause (c), that in fact this may be a more appropriate description of the cause for intervention than part of the definition. That is a reasonable argument and in fact that is where it's included later on in the bill. But I do not understand the policy difficulty of the government with respect to the appropriate, able person.

**Mr Jim Wilson:** Ditto Mrs Sullivan's remarks. We're very supportive of this clause, but I'm just wondering if the word "appropriate" may cause some problems down the road, should someone challenge that before the courts, because it is a fairly general concept. Does legal counsel have any thoughts on that?

**Ms Laura Hopkins:** The word "appropriate" is quite flexible. In deciding who an appropriate person would be, a court would have to take into account the other statutory rules governing who can give consent on a person's behalf.

**Mr Jim Wilson:** That clarifies that.

**Mr Winninger:** I just need to clarify a point with Ms Sullivan. If I tell you I'm a vulnerable person and I also tell you I have a family member who's been acting on my behalf for a long time and I agree that he or she is appropriate, able and willing to assist me but I would like someone with training, with expertise, who's accountable to this new Advocacy Commission to represent my interests as an advocate, your amendment to the definition would preclude that.

I would suggest to you that if your real intent is to restrict access to advocacy services where there is someone else involved, you might be better to look at section 7. I don't necessarily agree with such an amendment, but it flows more logically out of section 7, rather than in the definitional section.

**Mr Malkowski:** Just responding to Mrs Sullivan, I think the real issue here is that we're talking about the vulnerable individual having freedom of choice, and that's a personal choice for autonomy. If, for example, there is a family member who is identifying needs and has worked in terms of providing advocacy and the vulnerable person wants that family member to continue to act, there is certainly no difficulty in that, but there is a personal choice involved: that if the vulnerable individual wants an advocate, that should be there. It's definitely a personal choice issue.

1520

**Mr Sterling:** I just say in response that if a vulnerable person and his or her family member wanted the assistance of the Advocacy Commission, it's easy enough for the family member to say that he or she is not willing to assist and then the Advocacy Commission would kick into effect.

You're assuming that there is no conflict here, and I guess that's the problem. In an Alzheimer case, an advocate gets thrown into the mix, and the family member who is trusted by everyone is saying—

**Mr Jim Wilson:** "I'm second fiddle."

**Mr Sterling:** "I'm second fiddle in the care of my brother," or mother or whatever, so I don't see the same kind of objection as you do. If the family member said, "I want the help of the agency," which I would assume he would if in fact he were getting nowhere and were able and willing to act—if that was appropriate, then that would happen, wouldn't it?

**Mr Winninger:** Just briefly, you made two points. You raised the issue of a conflict between the vulnerable person and the family member. Clearly, we're trying to accord as much autonomy to the vulnerable person as we can. I would suggest that if I were to buy into your argument, that would require the family member, along with the vulnerable person, to decide whether or not an advocate should be involved.

Secondly, as a result of the convincing submissions made during the hearings, we have beefed up the sections that require advocates to work with family members. So I think that we've gone a long way towards meeting that concern.

**Mr Sterling:** I didn't say a conflict between the vulnerable person and the family member; I said a conflict between the advocate and the family member.



**Mr Winninger:** Once you get to the advocate stage. But if Ms Sullivan's definition remained as it was, you wouldn't necessarily invoke an advocate in this situation, because that person wouldn't be a vulnerable person to start with.

**Mr Malkowski:** Again, when we look at family members and the vulnerable individual, certainly if the vulnerable individual wants an advocate, that needs to be a choice available. It's important that the act points out—and that we recall when we're talking about the act—that there are cases where family members have abused vulnerable individuals. I'm saying that there are some cases where that happens. The issue is that there has to be personal choice available for any vulnerable individual in order to avoid any type of conflict from developing.

**Mr Sterling:** That, in theory, sounds appropriate. Isn't that covered in (b)? If there's a conflict in the family between the vulnerable person and the family member, then it's not appropriate.

**Mr Winninger:** What's not appropriate?

**Mr Sterling:** Representation of the person; that's what "appropriate" reads to me.

**Ms Carter:** That's subjective. Somebody else might say it was appropriate, and the person himself might not think so.

**Mr Jim Wilson:** Well, the whole thing's subjective. In part (a), if you're able to ask for an advocate, then are you vulnerable? You're able to express your wishes; along the same logic.

Section 3:

**The Chair:** We'll go on to subsection 3(1). Comments? Subsection 3(2).

Section 4:

**The Chair:** Mrs Sullivan moves that section 4 of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Minister

"4. The member of the executive council who is designated by the Lieutenant Governor in Council shall administer this act."

**Mrs Sullivan:** In commenting on this particular motion, this is really one of practicality. We know that governments change and the structure of governments change, and even the names of ministries change. By eliminating the specific reference to the designation of the Minister of Citizenship, that will allow the restructuring of cabinet responsibilities or even the renaming of cabinet responsibilities without reopening the bill. It's a very practical matter and I think one that's useful.

**The Chair:** Further comments? Mrs Carter.

**Ms Carter:** I appreciate your point about the restructuring of cabinet, but I think there was a reason here for designating the Minister of Citizenship, which should be kept in mind and not lightly thrown aside, and that is, we want all this to be very much at arm's length from government and not specifically to come under ministries like Health or Community and Social Services, which are big

administers of care that vulnerable people receive. So there was a rationale to this and I think we should think carefully before we disregard that.

**Mr Jim Wilson:** I think we're supportive of this amendment. What we just heard from the government side sounds like, "Well, the Ministry of Citizenship's a bogus enough ministry so it can deal with this legislation." I don't think you meant to say that, but that's what I heard.

Section 5:

**The Chair:** Subsection 5(1)? Subsection 5(2)? Mrs Sullivan?

**Mrs Sullivan:** Just a sec. Just hang on here, Mr Chairman. I have an amendment to subsection 5(2) and I just hope you'll bear with me while I get everything together here.

What I think we've been struggling with as we've gone through the makeup of the commission—can I speak to subsections 5(2), 5(5) and 6(1) at the same time?

**The Chair:** Sure. That'll be fine.

**Mrs Sullivan:** These are all interrelated, and I also would like to speak to the government's motion to subsection 6(1) at the same time.

As we've gone through the hearings, we've heard from various groups and organizations some concern about the nature of the commission's representation, people being left out, people being included, people who felt that the category should be changed, which I think comes up in a later amendment.

In terms of these four sections—and I'm going to speak about the government amendment too to subsection 6(1)—what we feel is that to ensure there is appropriate and adequate representation the commission should be really comprised of a chairman and 12 other members, to make a commission of 13 members.

The change to subsection 5(5) would require the government to make an order in council, replacement of a member if a vacancy occurs. In subsection 6(1), the amendment we are proposing would suggest a 13-member commission comprised of the chair, seven people who are physically or mentally disabled or likely to be—as is in the current proposals, ie, the majority—two members at minimum who would be 65 years of age or over, who also may be included in the prior category but who may not, and I note that the government in its amendment includes a provision for persons over 65.

We've had very strong recommendation with respect to the inclusion of organizations representing family and friends on the commission, and I've proposed that in that commission membership there should be two representatives from those types of organizations. That would leave, in the case of the entire commission, one other appointment to be made at large.

1530

We have really attempted to bring together the interests that have been very clear and the concerns that have been made very clear with this proposal about the nature and composition of that commission. Because we are suggesting that it be statutorily one chairman plus the 12 members, subsection 5(5) would change to ensure that the Lieutenant Governor in Council reappoints. Now there is



an option of not appointing, because of the peculiarity or variation that's allowed in the size of the commission, so that's why that amendment comes forward.

I also to want to say, as we're discussing this, that I am quite concerned about the drafting of the government's motion. It seems to me that the motion implies that one must be or must have been vulnerable, or that the majority must have a physical or mental disability or be likely to have one, or that the majority has to be over 65. My view is that this is not the government's intent, but I think that's the way this amendment proposal reads. I would not be supporting it in that form.

I do believe that people over 65 should have automatic places on the commission. I do believe that people who are friends and representatives of organizations representing friends and family should be included in that commission and that, by ensuring the size of the commission, we can accommodate many of the concerns we've heard. That's why these four amendments have been put forward in the form that they have.

**The Chair:** Would you like to move your—

**Mrs Sullivan:** Oh, yes, I guess I have to do that, don't I? Shall I read them all in?

**The Chair:** Yes, please.

Mrs Sullivan moves that subsection 5(2) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Composition

"(2) The commission shall consist of a chair and twelve other members, appointed by the Lieutenant Governor in Council on the minister's recommendation."

Mrs Sullivan moves that subsection 5(5) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "may" in the third line and substituting "shall."

**Mr Sterling:** Could we deal with just section 5 first and the other ones after that?

**The Chair:** Yes, we'll deal with section 5 first.

**Mr Sterling:** I just want to say that I sort of support the thrust of the Liberal motion, but I have a problem with the practicality of it in that sometimes it takes a little time to reappoint some people, even with the best of intentions. I don't know whether that would stymie the commission in terms of holding meetings and being able to function. That's a concern I have.

I'm satisfied that probably any government would appoint 12 people from the number of interest groups that are there. I don't know how you add some urgency to that in section 5; it's just that I don't think you can say the commission has to have 12 members appointed all the time. There has to be some flexibility in there. Maybe you want to say nine and up to 12. I just think it's a little impractical, due to death, illness or whatever might happen, that you can always have 12 members on a commission unless you have people literally in the waiting rings and you have a cabinet meeting about to happen and therefore appoint them. Perhaps before tomorrow you might want to take that into consideration.

**Mrs Sullivan:** I think the member has raised some of the concerns we had in putting this forward. Twelve is useful simply because of the composition. I would be interested, for instance, in saying "a minimum of 12 other members," which would provide a flexibility to ensure that kind of representation, but we might want to discuss this further. I think this is a useful recommendation, and I would be willing to adjust it so that it is a practical one as well as being a principled one.

Section 6:

**The Chair:** Mr Malkowski moves that subsection 6(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Criteria for appointment

"A majority of the members of the commission shall be (a) persons who have or who have had a physical or mental disability or an illness or infirmity likely to result in a physical or mental disability; or (b) persons who are 65 years of age or older."

**Mr Malkowski:** The reason for this motion is that we certainly heard from public submissions and public hearings a great number of concerns that the majority of those appointed to the commission actually be themselves disabled individuals and also be seniors. So many of the people who came out to speak, of course, felt that representatives in these categories may function very well and may in fact not be considered vulnerable at that point but would be able to express their wishes and needs to the commission.

**Mr Jim Wilson:** I understand, Mr Malkowski, the thrust of this government amendment, but I just wondered, to what extent does a potential appointee have to have had a physical disability? If you broke your leg once and you're fully recovered? I appreciate I'm playing devil's advocate, but it does raise that type of question. To what extent do you have to have been physically disabled, for example?

**Mr Malkowski:** If you're discussing the definition of "disability," the people who are going to be appointed will have been identified previously from the group, and it was "moderate to severe" as defined earlier.

**Mrs Sullivan:** I'd like a clarification of that. Remember, when the bill was first introduced in the House, the words were "physical or mental disability." Those words were changed in the first amendments to "vulnerable," now they've been changed back to "physical or mental disability."

In response to Mr Wilson's point, I think Mr Malkowski's discussion in fact reverted back to the "vulnerable" situation where a person has been identified as vulnerable, and I don't think his response was clear to the question that was put by Mr Wilson.

I would also like confirmation, whether it comes from Mr Malkowski or from counsel, as to whether this amendment will in fact have the effect of meaning that everyone who is in the majority on the commission shall be over 65, or is it one or the other?

**Mr Malkowski:** I think I'll ask legal counsel to respond.



**Ms Linda Perlis:** I wonder if I could address those points that Mrs Sullivan has raised before the committee. First of all, we are willing to consider that there may be a drafting error in the section. It wasn't the intent that the majority of members all be of the age of 65, and we're certainly willing to redraft that section. Thank you for drawing that to our attention.

I'd like to just clarify the intent of the new proposed amendment. I realize it's somewhat confusing, because it is the second time the government has proposed an amendment to that section, and if I quickly run through the history, that may clarify the intent of the amendment.

In the original bill the requirement was that a majority of the members of the commission be persons who have or have had a physical or mental disability, illness or infirmity, and that of course would have captured virtually every single person in this room, since we've all had a physical illness. So the change was made in the first round of proposed amendments to a majority of commission members being persons who are or have been vulnerable.

1540

Upon reflection and upon hearing submissions, we realized that in fact some very severely disabled persons who were well able to express wishes or access rights, and therefore were not vulnerable, might be excluded from the majority membership requirement for the commission yet would have a very deep appreciation of the needs and concerns of vulnerable people.

In response to Mr Wilson's point, the intent is that the person be disabled or have an illness or infirmity likely to lead to a disability, and I don't think a broken leg in and of itself constitutes a disability. However, it could be an infirmity with particular complications that may lead to a disability.

I think the intent also in the new motion is to capture persons who perhaps, although not yet disabled, have had a diagnosis of an illness or infirmity that is likely to result in a disability through the passage of time or deterioration of their condition, such as multiple sclerosis for example.

**Mr Jim Wilson:** Thank you for the explanation. I knew that's what this wording is trying to get at, but I don't believe that this wording does match that intent.

**Mr Stephen Owens (Scarborough Centre):** Just further to the point, my question to the counsel is the definition that the word "disability" or "infirmity" turns on, maybe to add some clarity to the question Mr Wilson is asking.

**Ms Perlis:** I think Mr Malkowski wants to answer that.

**Mr Malkowski:** Sorry, it was a point of clarification I was responding to. I had thought you were talking about somebody who had actually been an amputee. You were talking about somebody who had simply broken his leg, and certainly there's a distinction between that, so I just wanted to clarify that.

**Ms Perlis:** I just wanted to respond to Mr Owens's question. We don't have a definition of disability in the act. However, the World Health Organization has an extensive definition of disability which will be referred to in the preparation of policy and other documents by the commission, no doubt. Also, the HALS survey, the Health and Activity

Limitation Survey done of residents in Ontario, contains an extensive, detailed definition of disability which relies on the World Health Organization definition.

**The Chair:** Further comments?

**Mr Malkowski:** I think the concerns that were raised certainly are such that I think we could redraft that section to make the language a bit more appropriate and clarify that point for you.

**The Chair:** Further amendments to section 6? Mr Sterling? We'll try and keep it in order according to what we've got written down.

**Mr Sterling:** I'll put forward mine. I think when you look at the three suggestions for 6(1), they're sort of driving at the same things, and I'm not sure what combination is best to come to. Do you want me to move my amendment?

**The Chair:** Mr Sterling moves that subsection 6(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Criteria for appointment

"(1) The commission shall be constituted as follows:

"1. A majority of the members shall be persons who are or have been vulnerable persons.

"2. At least one third of the remaining members shall be persons who are family members of vulnerable persons, non-professional persons who provide care to vulnerable persons or health and social services practitioners who provide services to vulnerable persons."

**Mr Owens:** On a point of order, Mr. the parliamentary assistant's comment about redrafting, is the parliamentary assistant saying we're going to stand this section down for re-drafting, or what are we doing with this?

**The Chair:** Everything's being stood down until tomorrow. Go ahead.

**Mr Owens:** I understand it's being stood down until tomorrow, but in terms of redrafting—

**Mr Wessinger:** Let's stand them all down.

**Ms Perlis:** Before committing to a redrafting, the legislative counsel is here and I wonder if she could also just speak to the point about the confusion around the way the section is drafted and the rules for statutory interpretation, because it appears—

**Mrs Sullivan:** She wants to wait till tomorrow too.

**Ms Hopkins:** I understand completely everyone's discomfort around the way in which this is read because, as a matter of statutory interpretation, often "or" is read to mean "and." Sometimes it's read to mean "both (a) and (b)" and "(a) or (b)," and it's quite an arcane point of grammar in the statutory interpretative rules. The way in which this would be read by the arcane folks would be to understand that the majority didn't need to be either all of persons who have the disability or the infirmity or the other category, all of them being people who are 65 years of age or more.

My technical advice initially to the committee would be that the provision will work in the way in which we all would like it to, but it may be that it will be easier if we rewrite it to make it clear not only to the arcane troops but to everyone else that it works that way.



**Mr Wessinger:** I'd just like a point of clarification about what the redraft is going to address. I thought one of the points raised for clarification is—maybe I'm wrong—the physical or mental disability aspect: Would that cover the person with the broken leg or who is temporarily disabled due to an accident etc situation? I thought that was the issue we were looking at with respect to redrafting rather than the issue of the disjunctive—

**Mr Jim Wilson:** This is part of the overall. Interjections.

**Mr Winninger:** Looking at the big picture.

**Mr Jim Wilson:** Don't say I don't support you.

**Ms Carter:** I think part of the trouble, as I understand it, is that a vulnerable person is defined as somebody who has difficulty in expressing himself or herself or making his or her wishes known. Obviously, if you had a committee consisting of those people, you'd be in trouble, yet there are plenty of people who have disabilities who can make their wishes known without any trouble. Maybe those are the ones we want on the commission.

**The Chair:** This whole process may be moot until we see what they redraft.

**Mr Wessinger:** Mrs Sullivan and myself both raised the problem of the vulnerable people definition, and that's why I—

**Mr Malkowski:** Just to respond to Mr Wessinger, we were talking about redrafting only that one section. It would mean a few words.

**The Chair:** Thank you. Back to Mr Sterling's motion. Comment?

**Mr Sterling:** Basically, in my amendment I have two sections. The first section tries to deal with what is contained in subsection 6(1) and, quite frankly, I have no objection to the amended definition put forward by ministry, if that serves them. I still like the old definition, which referred back to the definition section. It seems to me just easier to do it that way, but I don't mind the addition of "persons who are 65 years of age or older" as part of that majority of the members of the commission. I don't disagree with the intention of the government motion.

I would like in my amendment to guarantee, on the other side of the coin, in the minority, that there be at least a third of the commission who are within this other category. That's the purpose of my submission: if it's a commission of 12 members, that four members are family members of vulnerable persons, non-professional persons who provide care to vulnerable people or the health and social service practitioners who provide services to vulnerable persons.

I would like to delete the word "remaining" out of my amendment as read into the record, because I meant "a third of the commission."

1550

**Mrs Sullivan:** In relation to Mr Sterling's motion, I think his approach is very interesting in the last paragraph. The first paragraph I think we've discussed, with reference to the inclusion of vulnerable persons on the commission. I prefer the approach of the government that the people with

disability, illness or infirmity are likely to have one, rather than the "vulnerable person," which is included there.

I think the inclusion of people who provide services, whether they are health and social services or care, is also an interesting concept. My amendments don't do that—I'll read mine into the record—but we certainly have had representation about this and I think the government should look at the second section seriously.

**The Chair:** Mrs Sullivan moves that subsection 6(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Criteria for appointment

"(1) A majority of the members of the commission shall be persons who have or have had a physical or mental disability or an illness or infirmity likely to result in a physical or mental disability.

"Representation of senior citizens

"(1.1) At least two members of the commission shall be persons who are 65 years of age or older.

"Representation of family and friends

"(1.2) Two members of the commission shall be persons selected from organizations that represent family members and friends of vulnerable persons."

**Mrs Sullivan:** I think I've discussed those and Mr Sterling's suggestions with reference to the variation in size. If I can be permitted to bring new motions before the committee tomorrow in that area in order to come to a compromise, I'd be delighted to do that.

**The Chair:** Would you like to move your alternative amendments too? Or you can wait until tomorrow, if you want.

**Mrs Sullivan:** Alternative 2: Do I need to do this? The government's already put forward—I guess I'd better, just in case.

**The Chair:** Mrs Sullivan moves that subsection 6(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Criteria for appointment

"(1) A majority of the members of the commission shall be persons who have or have had a mental or physical disability, illness or infirmity."

Mrs Sullivan further moves that section 6 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Representation of family and friends

"(1.1) Two members of the commission shall be persons selected from organizations that represent family members and friends of vulnerable persons."

**Ms Carter:** I think it needs to be pointed out that we have already allowed for an advisory committee which would represent categories of people other than actual consumers. I don't see us agreeing to the latter part of either of these amendments, because I think the whole heart and core of what we're trying to do here is to have consumers, people who have the same point of view of those who are going to be the clients of the advocates, running the commission. I think to make a concession on that would be to alter the whole intent of what we are trying to do in this Advocacy Act.



**The Chair:** Further comments? Seeing none—

**Mrs Sullivan:** Well, just a minute. I hope the statement from Mrs Carter does not represent the closed mind of the government on this issue. We have agreed that these recommendations would be considered overnight, and I really hope the government will look at that proposal in a very serious way. It's included as part of the omnibus amendment, and it's included separately, because it was very clear throughout these hearings that people who are from organizations representing people who are vulnerable, who are family and friends of vulnerable people, have no place in this entire Advocacy Commission structure.

An advisory committee is not a decision-making body, cannot participate in the responsibilities and the authority that is given, which is very broad and wide-ranging, to this commission. This commission, under this act, has the power to determine who can be advocates, how they will be trained, what their duties are, how they will be disciplined, when they can intervene, whose records they can see and how and when they will determine who is a vulnerable person.

Surely to goodness, no one can believe that a vulnerable person and the issues associated with vulnerability itself can only be understood by people who are themselves disabled. Other people live with disability; other people live with vulnerability; other people, whether they're health practitioners or families, care for people who are disabled and who are vulnerable and who are having difficulty in coping with life.

Surely to goodness, there can be a place made by this government for people who desperately and deeply care for people with disabilities and people who are vulnerable. Surely there can be a place.

**Mr Malkowski:** I certainly recognize Mrs Sullivan's concerns as they relate to this issue, but it is important that we also heard from a great number of people—including, for example, the Alzheimer society—who were comfortable with the idea of an advisory committee as opposed to a seat on a commission. I think that is an important point to be made.

**Mrs Sullivan:** That is a quite incorrect interpretation of the position of the Alzheimer society. They came before this committee very clearly disturbed that there would not be a place for organizations representing family and friends as part of the decision-making process associated with the commission. It was only when the government indicated, as a sop to those concerns, that a little advisory committee, with no powers and with no function outlined in the act, would be stuck in that the Alzheimer association even indicated any support for that. They want to be a part of the decision-making process, just as the Friends of Schizophrenics do, just as people who care in other ways and provide services in other ways for vulnerable people do.

**Mr Malkowski:** What's important is that we also take a look at the record, and Hansard certainly will show that there were a great number of people who said that they supported the advisory committee, including the Alzheimer society.

**Mrs Sullivan:** It's better than nothing, I suppose.

**Mr Malkowski:** Their presentation did clearly state that.

**The Chair:** Further comments or questions on section 6.

**Mr Jim Wilson:** Mr Chairman, I want to go back to a remark Mrs Carter made. I think she was correct. In one case, I can see that there might be a problem with the definition of vulnerable persons and the sections we're now dealing with. If you're a person with a mental disability and you're vulnerable, the definitions we've been dealing with are all problematic in that to be vulnerable you have to be unable to express your wishes, so how do you serve as a member of a commission? You'd need an advocate to help you express your wishes on a commission. It seems to me it's all problematic in that area. If we go ahead with what we've got, it means people who have a mental disability, are vulnerable and therefore qualify to be majority members on the commission—essentially, how would they function on the commission? Mrs Carter picked that up maybe 10 minutes ago.

**Mr Malkowski:** The government's motion addresses that by focusing on people with disabilities as opposed to only vulnerable individuals. So those people with disabilities are able to address those issues.

**Mrs Sullivan:** I would just like to point out, as my last remark in this area, that a person who is suffering from the advanced stages of Alzheimer's is clearly disabled and will never be able to serve on that commission simply from a functional point of view, and there would be no one representing that kind of person on the commission.

**Mr Malkowski:** The Alzheimer Association of Ontario said its preference was appointment to an advisory commission. That was very clearly stated.

**Mrs Sullivan:** On a point of order, Mr Chairman: That is not correct, and I'm going to make a formal request that the presentation of the Alzheimer association be brought to the committee before this vote is taken. That is a misrepresentation of the point of view of the Alzheimer association.

**Mr Malkowski:** Then I agree that we should check the record in Hansard and defer that point.

**The Chair:** Thank you. We'll have that before tomorrow.

**Mr Jim Wilson:** I just want Mr Malkowski to know that I now understand his point with regard to the term "disability" in subsection 6(1) in the government's amendment.

**Mr Sterling:** We basically support the amended decision over the existing decision, and I would incorporate that into my amendment as well.

**Mr Wessinger:** I'd like to ask for a point of clarification on Ms Sullivan's amendment. If I understand the effect of your amendment, it would change the act from the provision now that one person, perhaps, would be from organizations that represent family members and friends of vulnerable persons. If you look at paragraph 15(1)6, they have the right to nominate a member of the commission, am I right?

**Mr Winninger:** It's just the advisory. It's not to the commission.



**Mr Wessenger:** I see.

**Mrs Sullivan:** They're left out. I really think it should be rethought.

**The Chair:** Further comments or questions on section 6? Seeing none, this looks like an appropriate time for a five-minute recess.

The committee recessed at 1604.

1626

Section 7:

**The Chair:** I call this meeting back to order. We're now on section 7.

Mrs Sullivan moves that subclause 7(1)(b)(ii) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "if there is a risk" in the third and fourth lines and substituting "if there are reasonable grounds to believe that there is a risk."

**Mrs Sullivan:** This proposal reflects the similar criterion of reasonability that I put forward, I think, in the first amendment. I think the government and the third party indicated that they were interested in supporting that test.

**The Chair:** Further comments?

**Mrs Sullivan:** Should I go on to the next section?

**The Chair:** Mrs Sullivan moves that clause 7(1)(d) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"(d) provide rights advice required by the Consent to Treatment Act, 1992 and rights advice or other advocacy services required by the Consent and Capacity Statute Law Amendment Act, 1992, the Mental Health Act and the Substitute Decisions Act, 1992."

**Mrs Sullivan:** I wanted, in this amendment, to make a clear separation between the rights advice which is now required by Bill 109 and the rights advice and advocacy services which can be provided by the other bills. I think that if rights advice and advocacy are lumped together it's problematic in terms of dealing with Bill 109, so I thought it was reasonable to make that separation for clarity.

**The Chair:** Further comments?

**Mr Jim Wilson:** My comment on that goes back to a question I had asked one of the witnesses during the hearings. That would be that under Bill 109, where we now have rights advisers, we're unable to do advocacy services; therefore, I can see a situation where the rights adviser calls in the advocate. I think, with Mrs Sullivan's amendment, that really may not be possible, if you were to separate it as she has separated it. I know what she's trying to do, saying that in Bill 109 it only pertains to rights advice, but I think there are cases where you'd have rights advisers and advocates on the scene type of thing. Mr Fram indicates I may be wrong.

**Mr Steve Fram:** I think you're wrong.

**Mr Jim Wilson:** Well, then, if I'm wrong, I support Mrs Sullivan's amendment.

**The Chair:** Mrs Sullivan moves that clause 7(1)(h) of the bill, as reprinted to show the amendments proposed by the minister, be amended by inserting after "for the" in the third line "rights, needs."

**Mrs Sullivan:** This is identical to a previous amendment proposal with respect to full services and care for vulnerable people. As I recall, Mr Winninger indicated that the NDP supported that.

**Mr Malkowski:** Just in response to that point, I think I would have to say that we are going to stand down discussion of that at this point.

**Mr Jim Wilson:** Are you going to defer that discussion until tomorrow? We don't have a lot of time, so if there's work to be done on that, we kind of need to hear the government's comments now, Mr Chair.

**Mrs Sullivan:** My understanding was that we've had the government's comment.

**Mr Wessenger:** Are we on 7(1)(k)?

**Mrs Sullivan:** We are on 7(1)(h).

**Mr Wessenger:** We're not on (k) yet. I will wait with my comments.

**Mr Jim Wilson:** Mr Chairman, if we had agreement previously, this just brings another part of the bill in line with some previous agreement.

**Mr Malkowski:** I was talking about 7(1)(h).

**The Chair:** That's right.

**Mr Malkowski:** I think that's an interministerial issue that has to be discussed.

**Mrs Sullivan:** Could I ask why?

**Mr Malkowski:** It is an issue that will affect various ministries and so needs further analysis of the issue before responding.

**Mr Winninger:** Just for the record, I was stating my own views as a member of the government caucus on this committee. I don't speak for the NDP or for the Ministry of Citizenship, so if there seems to be a perceived conflict, I'm sure it can be resolved in the fullness of time.

**Mrs Sullivan:** Mr Chairman, could we assume that Mr Winninger is speaking for the Solicitor General? And if it is an interministerial issue—

**Mr Winninger:** No, I don't speak for the Solicitor General.

**Mrs Sullivan:** Or does the Attorney General support this amendment?

**Mr Malkowski:** On a point of order, Mr Chairman: I was trying to make a clarification before Mr Winninger began. I had said clause 7(1)(h); I should have said (d), not (h), that I was referring to on the interministerial issue.

**The Chair:** This is from the previous one.

**Mr Malkowski:** That's right.

**Mr Jim Wilson:** Would there be any government members who have any thoughts on (h), and would there be any government members capable of speaking for the government on (h)?

**Ms Carter:** I don't see any problems with it.

**Mr Winninger:** There you have it.

**Mr Jim Wilson:** That's two. Now, Paul, can we hear what you say, and Mark?

**The Chair:** Order, please.

Any further comments on 7(1)(h)? Seeing no further comments, Mrs Sullivan.

**Mrs Sullivan:** My next motion is somewhat more complicated in that it has to be read in conjunction with proposed amendments made to section 36 of the bill. I think that in view of that, I'd like to stand down this motion at this time so that it can be considered when we consider section 36.

**The Chair:** Agreed? Agreed.

**Mrs Sullivan:** That was in reference to alternative 1.

**The Chair:** Okay.

Mrs Sullivan moves that clause 7(1)(k) of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding at the end "and rights advisers."

**Mrs Sullivan:** Once again, because of the changes to Bill 109, the Consent to Treatment Act, what we will be seeing is a separation in the standards, the requirements, the duties and the obligations of rights advisers vis-à-vis advocates. As a consequence I've put this motion forward. I think it's a reasonable one and I hope that it will be accepted by government.

**Mr Wessenger:** Is this being stood down as well?

**Mr Sterling:** They're all standing down.

**The Chair:** No, this one has been moved. Comments?

**Mr Wessenger:** Yes. I have some concern about alternative 2 7(1)(k), for the simple reason that from the point of view of the Consent to Treatment Act there is a provision under that act that not only advocates are rights advisers but also there may be other designated persons to be rights advisers. I think there could be some problems created in respect to the creation of a potential accountability of rights advisers appointed under one ministry having accountability to a different ministry. I therefore would be opposed to this.

**Mr Sterling:** Can I ask a question on this, because I consider it the same kind of amendment, in terms of the Advocacy Commission. What I don't understand is, what is their relationship going to be with rights advisers who may be appointed or defined under Bill 109? I think they're subscribed to in the regulations under 109. What is the relationship going to be between those rights advisers and the Advocacy Commission? Is there going to be any?

**Mr Wessenger:** At the present time it's contemplated that rights advice will be given by advocates, but the act—

**Mr Sterling:** Would you repeat that? I didn't hear you, sorry.

**Mr Wessenger:** The apparent intention is that rights advice will be provided by advocates, but there's also the option in the Consent to Treatment Act that the ministry can designate other persons to provide rights advice, which could conceivably happen with respect to some of the large institutions. For instance, the public hospitals would be an area where you could in future conceivably have a different system of providing rights advice than under the Advocacy Commission. It's looking at possible future contingencies.

**Mr Sterling:** Is there not—

**The Chair:** Thank you, Mr Wessenger. Mrs Sullivan.

**Mrs Sullivan:** I think there are several amendments related to this point throughout our amendments. Frankly, there is enormous concern about this entire area. There is confusion about this entire area.

Bill 109 speaks about rights advisers providing advice required by that bill in terms of basically rights advice, process advice etc. Bill 74 deals with rights advice and other advocacy services which may be provided in association with Bill 108, with Bill 109 and with Bill 110, and that is the provision of this bill.

It is unclear whom rights advisers under Bill 109 are responsible to, where their discipline and authority comes from, who pays them. We've heard throughout the hearings, and the implication is before the committee, that the work of advocates and presumably rights advisers—because in the original draft of these bills rights advisers were not separated from advocates—must be separated from the institutions which provide other services, whether they're health care services, vocational services etc.

1640

Through the hearings on Bill 109 when the Ontario Hospital Association was before us, when the College of Physicians and Surgeons was before us, I specifically asked questions as to what their understanding was of their role in providing the rights advisers envisaged under Bill 109.

It came as somewhat of a surprise to them when I indicated that in my view, the government intended that those rights advisers would be employed by those institutions at those places, paid for not by the government. The shock from the hospital association was significant, the shock from the medical practitioners was significant.

However, because of the vagaries of Bill 109 and where rights advice will be required because of the determination of incapacity to consent, there were certainly unclear matters, and this is one of the very specific reasons we wanted the ministers attending at this table. Hospitals do not know if they are going to have to employ around-the-clock, 24-hours-a-day, 365-days-a-year personnel on their staff to provide rights advice, and if so, they don't know where the money is going to come from in order to do that. That is a big problem in Bill 109. There is no answer in Bill 109 to that question. There is no answer in Bill 74 to that question.

If rights advisers are authorized to provide information and assist people under Bill 109, how are they authorized to do that? There is no place, unless a new section under Bill 74 provides that or unless perhaps the Consent and Capacity Review Board, under Bill 109, provides for that. Neither occurs now. These are separate functions by separate people.

I agree that advocacy includes in certain circumstances the provision of rights advice. Bill 109 limits rights advice to rights advice and no other advocacy services. That was a change that was brought forward by the ministry. Who authorizes them? Who provides their training? Who provides their discipline? Who provides the standards? Who pays for them? All of these things are very unclear.



As a consequence, whether rights advisers will in fact be independent of the facilities where they are providing that rights advice, independent of nursing homes by example, independent of controlled-access residences and therefore paid for by the commission, or whether they will be a part of those facilities and institutions is unknown at this point, so there is a series of amendments here that are designed specifically to force the government to own up to what its direction is. Nobody knows.

**Mr Jim Wilson:** It's a very good point. I'd be interested to hear what the government has to say in response to those comments.

**Mr Malkowski:** Again, I think that many of these issues are going to touch on various ministries and that we need to look at this as an interministerial issue that has to be discussed.

**The Chair:** Further comments or questions?

**Mrs Sullivan:** Could I ask at least one thing? This isn't public hearing time, but I would like to ask one question. What is the policy intent with respect to the independence of rights advisers from the institutions or facilities where services are provided? I guess I have to ask that of the PA to the Minister of Health.

**Mr Wessenger:** The intention of these three acts being together is that rights advice be provided by advocates. However, I think it's only fair to say in drafting legislation, you want to have the flexibility to provide for other contingencies. It's clear you'd want to have that flexibility in all your legislation with respect to how you deliver your services.

No one knows whether, for instance, in the future when the need for rights advisers arises, there may be other mechanisms in health institutions that may be more efficient in delivering those services than the one under the Advocacy Commission. That is just to preserve that flexibility. There's no policy intent, I can assure you, to create a separate set of rights advisers. There is no intent to require hospitals to have rights advisers on staff etc.

**Mrs Sullivan:** We've had expert testimony before this committee indicating that in any hospital, not just one but substantial numbers of rights advisers would be required to fulfil the functions that would be required under Bill 109. The estimates from the downtown Toronto hospitals have been that there would not be just one needed on a 24-hour basis, around the clock, but substantial numbers, perhaps 10, 15 or 20.

How many advocates, who are going to be providing that rights advice, are going to be situated in downtown Toronto hospitals and in every other hospital around the province? Does anyone know? What about doctors' offices? What about dentists' offices?

**Mr Wessenger:** I think it's probably more appropriate, if we're going to get into the question of rights advice under the Consent to Treatment Act or the whole question of numbers, that it be discussed under clause-by-clause on that rather than at the time we're dealing with this act.

**Mrs Sullivan:** Where does their authority come from? Does it come from the commission? If yes, then let's

include them in the authority of the commission. If their authority doesn't come from the commission, then let's not.

**Mr Wessenger:** I think it's fair to say that this is a matter that has to be resolved between the ministries with respect to the whole question of accountability of any future rights advisers. That's a matter that has to be interministerially decided.

**Mrs Sullivan:** How many years do you expect it's going to take you to implement these bills? If these bills are proclaimed within the next six or eight months, you are going to need rights advisers in every institution where controlled acts take place.

**Mr Wessenger:** I think it's fair to say our ministry does not anticipate the numbers of rights advisers required as some institutions have indicated. The way the Consent to Treatment Act has been redrafted, with the new changes, we didn't anticipate a major requirement in that regard; it would be very few.

If we look at the experience with respect to psychiatric hospitals, certainly it's been minimal exercise of rights even within the psychiatric hospitals. So I don't anticipate, and certainly our ministry does not anticipate, a major demand or need for rights advisers in the health facilities. We do not see that; we don't anticipate that.

**Mrs Sullivan:** The Ontario Hospital Association told us that to deal with emergency cases alone it would require not just one but more than one rights adviser in every hospital in Ontario. What about other situations?

**Mr Wessenger:** I think we shouldn't get into debate on the Consent to Treatment Act at this time, because my answer to that would be to refer to the emergency section, which doesn't require rights advisers.

**Mr Jim Wilson:** It's a very good point. When the government came back with its amendments that appear in the reprint, the Bill 109 advocates were then called rights advisers. I remember hearing testimony from a member of the Ontario Advocacy Coalition on the fact that rights advisers would probably get paid less than advocates.

I had in my mind that we had two sets of armies out there and that they were both accountable to the commission. Therefore Mrs Sullivan's attempt to make them accountable to the commission makes sense. I thought it was just an oversight on behalf of the government that we're currently trying to clear up. Now the parliamentary assistant says that advocates will provide the rights advice under the Consent to Treatment Act.

1650

It also figures into how many advocates will be hired; 250 was one of the figures and that went down to 125 from the government side, because the other people would be rights advisers. It seems to me there are two separate entities here—there are persons called rights advisers and there are persons called advocates—and the problem is, as Mrs Sullivan is correctly highlighting, that rights advisers, whoever they may be, appear to be accountable to no one, and if they are to be accountable to the commission and hired and paid by the commission, then they should appear, I would think, in this act. Hence, we support her amendment.



**The Chair:** Just for the record, the clerk has just handed out from the Ministry of Health a legal opinion on consent in minors.

**Mr Winninger:** I just want to add that I, for one, don't share the opposition members' alarm over this. I'm aware that presently there are rights advisers functioning in mental health facilities. I am aware that many of Ontario's public hospitals have patient advocates already working within the hospitals. I'm also aware that many of the public hospitals sign forms that automatically require lawyers to come in who function as rights advisers and are paid for through legal aid on a fixed sort of tariff for one hour of advice or whatever.

So there already is a system in place that's working reasonably well, and I would expect that some changes would be required. For the opposition members to say, "Well, you haven't thought about this," and, "Where are they going to get their authority from?" and, "Who are they going to be accountable to?" I don't know that the present system of rights advice requires this massive overhaul that you seem to think it does.

**Mrs Sullivan:** If I could, I'm going to read all of these amendments in, and I think that we need some better response than what we've had.

Mr Winninger has just made the point about people who are providing rights advice who are employed by the institutions and the facilities where that rights advice is given. The government members of the committee nodded in agreement and indeed gave vocal support to the views that were put before the committee, through the public hearing process, that advocacy services and rights advice must be independent of the facilities and the institutions in which it was given because of the conflict of interest associated with the provision of that advice and because of the difficulties faced by the employee in terms of providing advice which may put him into a conflict situation with either another employee or the facility itself.

I have asked today for a policy clarification of the intent of the government with respect to the independence of rights advisers from the facilities or controlled-access residences where the rights advice might be provided, and I have not been able to get that. I get kind of a reassurance that things aren't going to be as bad as we think they are.

There is a principle at issue here and there is a policy matter at issue here, and I want to read these amendments into the record with respect to Bill 74. I think the authority and the areas of conflict of interest which are integral to the consideration of these amendments have to come forward.

Once again, I suggest to you that we are already now in clause-by-clause. This isn't a time where, unless the government is willing to do so, we should go back into public hearings to get more advice. We're down to the decisions and nobody knows what the government's policy intent is.

I'd like to read these into the record, and I will request that the response with respect to the policy intent and direction be provided to this committee before any votes are taken. We must have that information.

**The Chair:** Mrs Sullivan moves that clause 7(1)(k.1) of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subclause:

"(i.1) the authorization of persons or organizations or of persons employed by a facility or controlled-access residence under subsection (2.1) to perform functions on behalf of the commission."

Mrs Sullivan further moves that clause 7(1)(k.2) of the bill, as reprinted to show the amendments proposed by the minister, be struck out.

**Mrs Sullivan:** There are other amendments later on. I suppose I should go to those in order, though, so I'll leave those for now.

**Mr Jim Wilson:** I am certainly willing to go on at this point and just deal with advocates in Bill 74. I will say, for the record, that if Mr Winninger and the government are satisfied with that—and his remarks did help satisfy me that rights advice is now being provided in hospitals and health care settings—and with the role of rights advisers, then I'm certainly willing to take that into consideration.

I just want to make the point that it wasn't my party that went out and made all these promises about advocates in hospitals. I'd just as soon not see them there. The reason I was alarmed by this is that when Mr Wessinger told me that rights advisers were really advocates, I thought, well, we're back to where we were with draft one of this legislation. I just want to make that clear. I'm quite content to take the government's word—and my own experience would indicate—that a great deal of rights advice is now being provided in hospitals. If this new legislation reflects the status quo, I would agree with the government that rights advisers as envisioned in this legislation are appropriate.

**Mr Malkowski:** For a point of clarification on the point you were discussing, Mr Wilson, I'd like to refer to our policy person.

**Ms Mary Beth Valentine:** Just for clarification, rights advice as it's now provided under the Mental Health Act in the psychiatric hospitals is provided through the advocate office, so rights advisers don't report within the institution; they report to the psychiatric patient advocate office. When rights advice is provided in psychiatric units in general hospitals, rights advice is provided by legal aid. So in neither situation is it provided within the institution. The independence is there.

**Mr Winninger:** I just wanted to clarify something that was said earlier that Mr Wilson responded to. I wasn't suggesting that we were satisfied with the status quo; I was just suggesting that the status quo provides a basis to build on. It's not as though we're operating in a vacuum in terms of rights advice right now, and I think Mr Wilson agrees with that.

I want to move that we adjourn the debate today. I don't know what the feelings of the opposition members are, but I just had a chance to speak to the Conservative members—

**The Chair:** No discussion. Mr Winninger has moved that the committee adjourn till tomorrow. All those in



favour? Opposed? The committee members have to vote. All those in favour of adjournment till tomorrow?

**Mr Malkowski:** Could we have a five-minute break just to hold this for a moment?

**The Chair:** Too late. We're already conducting the vote, unless Mr Winninger would like to withdraw his motion to adjourn in favour of a five-minute recess.

**Mr Winninger:** If my colleague wishes to have a recess, I'd be prepared to withdraw the motion.

1700

**Mr Jim Wilson:** Let's just go on friendly agreement here to go a little longer. We've got quite a few to go through and we are under a deadline.

**Mr Wessinger:** If I could make a suggestion, I think it might be more productive if we spent the rest of the day just moving the amendments and defer discussion on them until tomorrow. That would make sense. I am just making the suggestion to save time. The problem is that there are a lot of interministerial problems raised by some of the amendments and some definition problems that would benefit from discussion. It would be more beneficial to have the discussion tomorrow, but rather than waste today, why don't we move the amendments today and defer discussion until tomorrow?

**The Chair:** Is there agreement to just just reading the amendments?

**Mr Sterling:** Mr Chairman, I would suggest that you read in the proposed amendment and that the proposer of the amendment explains the thrust of it, and that would be it. If anybody wants to say yea or nay that we limit it to that kind of discussion—

**The Chair:** And we can get into the discussion tomorrow. Are we agreed that we'll move them with a brief comment?

**Mr Wessinger:** Move the amendments, but we still have the right to have discussion on the amendments tomorrow.

**The Chair:** Tomorrow, time permitting, of course.

**Mr Jim Wilson:** And today if it's brief.

**The Chair:** Agreed? Okay.

Mrs Sullivan moves that clause 7(1)(k.2) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"(k.2) establish, subject to the approval of the minister, and make available to any person on request, a written review procedure for dealing with complaints from any person relating to advocates or rights advisers."

**Mrs Sullivan:** I want to you note that that's alternative 2.

**The Chair:** Mrs Sullivan moves that clause 7(1)(k.3) of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding at the end "and rights advisers."

Mrs Sullivan further moves that clause 7(1)(l) of the bill, as reprinted to show the amendments proposed by the minister, be amended by inserting after "advocates" in the first line "rights advisers."

Mrs Sullivan further moves that subsection 7(2) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "non-profit community agencies that do not provide services to vulnerable persons, other than advocacy services" in the first, second, third and fourth lines and substituting "non-profit community agencies."

Mrs Sullivan further moves that section 7 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Persons and organizations

"(2.1) The commission may authorize persons or organizations or persons employed by a facility or controlled-access residence to perform functions set out in clause (1)(d) on behalf of the commission, subject to such terms and conditions as the commission considers appropriate."

Mrs Sullivan further moves that section 7 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Authorization of rights advisers

"(4.1) The commission may authorize a person who works for a facility or controlled-access residence to provide rights advice on behalf of the commission, subject to such terms and conditions as the commission considers appropriate."

Mrs Sullivan further moves that clauses 7(5)(c) and (d) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"(c) persons who provide care and services to vulnerable persons."

Section 8:

**The Chair:** Mr Winninger moves that the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following section:

"Delegation of powers, etc

"8.1(1) The commission may delegate in writing any of its functions, powers or duties under the act to the chair or to any member or group of members and may impose such conditions and restrictions as it considers appropriate.

"Subdelegation by chair

"(2) The chair may delegate in writing to any person employed by the commission any function, power or duty of the commission delegated to the chair and may impose such conditions and restrictions as he or she considers appropriate."

**Mr Sterling:** I just want to say briefly that I have some concern about subsection 8.1(2) of the government motion, dealing with information and the delegation of that to a bureaucrat. I find a great deal of difficulty with that concept.

Section 9:

**The Chair:** Mrs Sullivan moves that subsection 9(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Protection from personal liability

"(1) No proceeding for damages shall be instituted against any of the following persons for any act done in good faith in the execution or intended execution of the

person's duty or for any alleged neglect or default in the execution in good faith of the person's duty:

"1. A member of the commission.

"2. An advocate or other person who works for the commission or a community agency, whether on a paid or voluntary basis.

"3. A rights adviser who works for the commission or for an organization, facility or controlled-access residence, whether on a paid or voluntary basis."

**The Chair:** Mr Sterling moves that subsection 9(1) of the bill be amended by deleting the words "or for any alleged neglect or default in the execution in good faith of the person's duty."

For clarification, are you talking about the reprinted bill?

**Mr Sterling:** Yes, I am.

Section 10:

**The Chair:** Mrs Sullivan moves that clause 10(1)(a) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"(a) shall establish a committee composed of persons from the groups described in subsection (2) to advise the commission; and."

Mrs Sullivan further moves that paragraph 2 of subsection 10(2) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "non-professional" in the first line.

Mrs Sullivan further moves that section 10 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsections:

"Functions of committees

"(3) The committees shall advise the commission on issues referred to them by the commission and may advise the commission on such other matters as the committees consider appropriate.

"Meetings

"(4) The committees shall meet regularly.

"Reports

"(5) The commission shall include any reports made to it by the committees in its annual report under subsection 11(1)."

1710

Mr Sterling moves that section 10 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsections:

"Functions

"(3) The committee established under clause (1)(a) has the following functions:

"1. To evaluate and comment on the effectiveness in relation to the families of vulnerable persons of the commission in providing advocacy services to vulnerable persons.

"2. To comment on the impact of the delivery of advocacy services on the delivery of health and social services.

"3. To review the policies and procedures of the commission and to advise the commission about policies and procedures.

"(4) The chair of the committee established under clause (1)(a) shall be appointed from among the members of the committee.

"(5) The chair and the other members of the committee established under clause (1)(a) shall hold office for three-year terms and may be reappointed for one further three-year term.

"(6) The committee established under clause (1)(a) shall meet at least once a month.

"(7) The chair and the other members of the committee established under clause (1)(a) shall be paid the remuneration fixed by the Lieutenant Governor in Council."

Section 11:

**The Chair:** Mr Sterling moves section 11 of the bill be amended by adding thereto the following subsection:

"(3) The advisory committee shall table an annual report for the Legislative Assembly if it is in session or, if not, at the next session."

Again, for clarification, you're talking about the reprinted bill.

**Mr Sterling:** Thank you, yes.

Section 15:

**The Chair:** Mr Malkowski moves that paragraph 2 of subsection 15(1) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "diabetes or a learning disability" in the fourth and fifth lines and substituting "or diabetes."

**Mr Sterling:** We agree with that amendment.

**The Chair:** Mr Malkowski moves that paragraph 6 of subsection 15(1) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "or traumatic head injury" in the fourth line and substituting "traumatic head injury or a learning disability."

**Mr Sterling:** We also agree with that one.

**The Chair:** Mrs Sullivan moves that paragraph 6 of subsection 15(1) of the bill, as reprinted to show the amendments proposed by the minister, be amended by inserting after "syndrome" in the fourth line "schizophrenia."

Mr Malkowski moves that subsection 15(2) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"(2) In order to participate in the nomination process, an organization must have at least 20 members and,

"(a) in the case of an organization described in paragraph 1, 2, 3, 4, 5, or 6 of subsection (1), a majority of the members must be or have been persons who are described in the applicable paragraph as being represented by the organization;

"(b) in the case of an organization described in paragraph 7 of subsection (1), a majority of the members must be or have been persons with a disability referred to in paragraph 1, 2, 4, 5 or 6; and

"(c) in the case of an organization described in paragraph 8 of subsection (1), a majority of the members must be or have been persons who are receiving or have received health care services and who are concerned about their rights in that context."



Mrs Sullivan moves that the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following sections:

**"Advocacy Review Board"**

"15.0.1(1) A board to be known as the Advocacy Review Board is hereby established.

**"Functions of the board"**

"(2) The board has the following functions:

"1. To consider complaints relating to the conduct of advocates and rights advisers who provide advocacy services on behalf of the commission.

"2. To hear appeals from decisions or findings of advocates and rights advisers.

"3. To consider complaints relating to the commission's performance of its functions.

"4. To hear appeals from decisions or findings of the commission.

"5. To issue directives concerning the circumstances in which advocates and rights advisers are required to provide the advocacy services required under the act.

**"Powers of the board"**

"(3) The board has the powers necessary to perform its functions and, in particular, may,

"(a) investigate and hold hearings into complaints;

"(b) impose disciplinary measures against an advocate or rights adviser that the board determines has acted improperly, including directing the commission to dismiss him or her for cause;

"(c) substitute its decision or finding in a matter complained of for that of the advocate, rights adviser or commission and direct a course of action to be followed.

**"Procedure"**

"(4) The chair of the board may make rules governing the procedure to be used in hearings before the board.

**"Composition of panels"**

"(5) The chair shall determine the composition of each panel of the board that holds a hearing relating to a complaint or an appeal. A panel may consist of either one or three members, as the chair determines.

**"Composition of the board"**

"15.0.2(1) The board shall consist of such members as may be appointed by the Lieutenant Governor in Council.

**"Ineligibility"**

"(2) A person is not eligible to be appointed as a member of the board if she or she is employed,

"(a) by the commission;

"(b) by a community agency that provides advocacy services to vulnerable persons;

"(c) by an organization that provides health care, housing or vocational or other services to vulnerable persons; or

"(d) at a facility.

**"Chair"**

"(3) The Lieutenant Governor in Council shall designate one member as chair and one or more others as vice-chairs.

**"Service"**

"(4) The members shall serve on a part-time basis.

**"Term and reappointment"**

"(5) The members shall hold office for three-year terms and may be reappointed.

**"Vacancies"**

"(6) If a member's position becomes vacant, the Lieutenant Governor in Council may appoint a replacement to serve for the remainder of the member's term.

**"Same, chair"**

"(7) If the chair is unable to act for any reason, a vice-chair may act in his or her place.

**"Remuneration and expenses"**

"(8) The members shall be paid the remuneration fixed by the Lieutenant Governor in Council and the reasonable expenses incurred in the course of their duties under the act.

**"Staff"**

"(9) Such employees as are necessary for the proper conduct of the board's work may be appointed under the Public Service Act.

**"Complaints to the board"**

"15.0.3(1) Any person may make a complaint to the board in writing,

"(a) about the conduct of advocates and rights advisers who provide advocacy services on behalf of the commission; or

"(b) relating to the commission's performance of its functions.

**"Appeals"**

"(2) Any interested person may appeal a decision or finding of an advocate, a rights adviser or the commission by giving notice in writing to the board.

**"Consideration by the board"**

"(3) Upon receiving a complaint or notice of an appeal, a panel of the board shall hold a hearing into the matter and make a decision.

**"Legal representation"**

"(4) A party to a hearing and any witness participating in the hearing is entitled to be represented by a lawyer at the hearing.

**"Decision re frivolous complaint"**

"(5) If the board determines that a complaint or an appeal is frivolous, it may impose a penalty of up to \$1,000 on the person who made the complaint and may direct that any or all of that sum be paid to persons against whom the complaint was made.

**"Compliance by commission"**

"(6) The commission shall comply with any directions issued to it by the board relating to a complaint.

**"Publication of decisions"**

"(7) The board shall provide a copy of its decision following a hearing to persons who request a copy."

**Mr Sterling:** Mine is somewhat similar in putting forth a complaints review committee, but is perhaps a little more succinct.

1720

**The Chair:** Mr Sterling moves that the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following section:

**"Complaints review committee"**

"15.0.1(1) The commission shall establish a committee to be known as the complaints review committee.

**"Composition"**

"(2) The committee shall be composed of such number of members as the commission determines and,

"(a) one third of the members shall be appointed by the commission; and

"(b) two thirds of the members shall be appointed by the advisory committee established under clause 10(1)(a) from among its members.

"Functions

"(3) The committee has the following functions:

"1. To consider complaints relating to the conduct of advocates and relating to the commission's performance of its functions.

"2. To hear appeals from decisions or findings of advocates or of the commission.

"Powers

"(4) The committee has the powers necessary to perform its functions and, in particular, may,

"(a) investigate and hold hearings into complaints;

"(b) substitute its decision or finding in a matter for that of the advocate or commission; and

"(c) impose disciplinary measures against an adviser that the committee determines has acted improperly."

**Mr Jim Wilson:** I think it would be helpful, before we all spend a great deal of time this evening further refining either a review board or a complaints committee, to hear whether the government has any interest in this area.

**Mr Malkowski:** I'm sorry, Mr Wilson, could you repeat your question?

**Mr Jim Wilson:** Yes. Given that there are two amendments, both setting up similar boards or committees, and the government has not brought forward a similar amendment, what is the government's frame of mind with respect to either an advocacy review board or a complaints committee?

**Ms Carter:** I think I can say that we feel it's not really appropriate.

**Mr Sterling:** It's up to these people to be accountable.

**Ms Carter:** There's a comparison with, for example, what happens in the law society where a lawyer who doesn't shape up is disbarred from his whole practice, not just loses one particular employer, and we're not in that kind of situation in the Advocacy Commission. It's not comparable to that kind of situation.

**Mr Sterling:** Why not?

**Mr Jim Wilson:** If Ms Carter's finished, I would just say that I really disagree and I would hope the government will reconsider this. Given its own model in the regulated health professions acts and at least accountability within colleges, I would think there'd be some members of government over there eager to address this issue.

**Mr Malkowski:** I'd like to respond to Mr Wilson. I think this is something we will have to be discussing and considering this evening and respond tomorrow to that.

**Mr Jim Wilson:** Okay, that's fair.

**Mr Wessinger:** I just want to add that I find Mr Wilson's remarks persuasive and I think various models should be looked at in this regard, as the parliamentary assistant for Citizenship has indicated will be done.

**Mrs Sullivan:** As you're considering this then, if you are going to have a serious look at complaints procedures, I think it's clear that the opposition parties are coming from a similar direction. One of the things that was raised as a matter of concern was the independence of a complaints process from the commission itself, and I think that's a matter we'd certainly like the government to have on the table as well.

**The Chair:** Mrs Sullivan moves that section 15.1 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Capacity to instruct

"(1.1) A vulnerable person is capable of instructing an advocate if the person,

"(a) is able to understand the information that is relevant to giving instructions in the circumstances and to appreciate the reasonably foreseeable consequences of the instructions; or

"(b) is able to express, in some manner, his or her instructions or wishes."

Mrs Sullivan moves that subsection 15.1(3) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "incapable" in the fourth line and substituting "capable."

Mr Malkowski moves that section 15.1 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Capacity to instruct

"(4) A vulnerable person is capable of instructing an advocate if the person is able to indicate a desire for advocacy services and the purpose for which he or she wishes to receive the services."

Mrs Sullivan moves that section 15.3 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Revocation of instructions

"(3) The vulnerable person or a person who is authorized to instruct an advocate respecting a vulnerable person may revoke or revise instructions to the advocate."

Mr Jim Wilson moves that the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following section:

"Appeal re status

"15.4 An advocate who determines that a person is a vulnerable person shall,

"(a) advise the person that the advocate has made that determination and the reasons for the determination;

"(b) advise the person that he or she may request the commission to review that determination in accordance with its review procedures; and

"(c) advise the person that he or she is entitled to consult a lawyer."

Section 17:

Mrs Sullivan moves that section 17 of the bill, as reprinted to show the amendments proposed by the minister, be struck out.



This motion is out of order and you need unanimous consent. Do we have unanimous consent? That's just to move it.

**Mrs Sullivan:** Yes.

**The Chair:** Do we have unanimous consent to move it? Agreed.

Mrs Sullivan moves that subsection 17(2) of the bill, as reprinted to show the amendments proposed by the minister, be amended by inserting before "controlled-access" in the first line and in the sixth line "facility or" in each case.

Mr Sterling, one moment please.

**Mr Sterling:** I'm just trying to compare these sections here. I wonder whether my amendment is identical to that of Mrs Sullivan.

**Mr Jim Wilson:** I think it is.

1730

**Mr Sterling:** My amendment is exactly the same amendment.

**The Chair:** Would you like to withdraw yours?

**Mr Jim Wilson:** No, enter it into the record.

**Mr Sterling:** No, I'll withdraw it.

**The Chair:** Thank you, Mr Sterling.

Section 18:

**The Chair:** Mrs Sullivan moves that section 18 of the bill, as reprinted to show the amendments proposed by the minister, be struck out.

Again, we would need unanimous consent to move this motion. Agreed.

Mrs Sullivan moves that section 18 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Entry to private dwellings

"(1.1) Despite subsection (1), an advocate is not entitled to enter a private dwelling without a warrant for entry."

**Mr Sterling:** That one was faintly familiar with mine, and therefore I will withdraw mine.

**Mr Jim Wilson:** The word "identical" comes to mind.

Section 19:

**The Chair:** Mrs Sullivan moves that subsection 19(1) of the bill be struck out and the following substituted:

"Warrant for entry

"(1) A justice of the peace may issue a warrant to an advocate for entry to premises if the justice of the peace is satisfied that,

"(a) the advocate has reasonable grounds to believe that there is a risk of serious harm to the health or safety of a vulnerable person in the premises;

"(b) the advocate has reasonable grounds to believe that a vulnerable person wants the services of an advocate; or

"(c) a meeting with a vulnerable person is necessary to fulfil the purposes of the act."

Once again, we're discussing the reprinted bill, at the very beginning?

**Mrs Sullivan:** Yes.

**The Chair:** Mrs Sullivan moves that section 19 of the bill, as reprinted to show the amendments proposed

by the minister, be amended by adding the following subsections:

"Premises

"(6) The warrant authorizes the advocate to enter only the common areas of the premises including the entryways, hallways, elevators, stairs and common rooms.

"Consent re private dwelling units

"(7) The advocate may not enter a private dwelling unit or a private room in a facility or controlled-access residence or other premises without the consent of the vulnerable person.

"Departure

"(8) The advocate must leave the premises promptly if the vulnerable person indicates that he or she does not want the services of an advocate."

Section 24:

**The Chair:** Mrs Sullivan moves that subsection 24(2) of the bill, as reprinted to show the amendments proposed by the minister, be struck out.

Once again, unanimous consent? Agreed.

Mrs Sullivan moves that subsection 24(3) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "incapable of instructing an advocate" in the second and third lines and substituting "incapable of consenting to access to the person's records."

Mrs Sullivan moves that subsection 24(4) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "incapable of instructing an advocate" in the second and third lines and substituting "incapable of consenting to access to the person's records."

Mrs Sullivan moves that the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following section:

"Capacity to consent to access

"24.0.1(1) A vulnerable person is capable of consenting to access to records if the person understands,

"(a) the subject matter for which the consent is required; and

"(b) the reasonably foreseeable consequences of giving or refusing to give his or her consent.

"Assessment

"(2) An advocate who considers a vulnerable person to be incapable of consenting to access to records shall ensure that the capacity of the person is assessed by an assessor authorized under the Substitute Decisions Act, 1992.

"Appeal

"(3) If the assessor determines that the vulnerable person is incapable of consenting to access to records, the advocate shall,

"(a) advise the person in writing that the assessor has made that determination; and

"(b) advise the person that he or she may appeal that determination to the Consent and Capacity Review Board as if the determination had been made under the Consent to Treatment Act, 1992.

"Stay pending appeal

"(4) If the determination is appealed, the advocate shall not seek access to the vulnerable person's records under

subsection 24(2) or (4) until the board disposes of the appeal."

**Mr Sterling:** I'm going to withdraw that amendment; it's somewhat similar.

**The Chair:** Mrs Sullivan moves that the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following section:

"Request for access to records

"24.1(1) An advocate who wishes access to particular records shall make a written request to the operator of the facility, controlled-access residence or program prescribed by the regulations made under this act, as the case may be.

"Application to withhold records

"(2) The operator may apply to the Consent and Capacity Review Board for permission to withhold all or part of the records sought by the advocate and shall give written notice of the application to the advocate.

"Determination by the board

"(3) Within seven days after receiving the application, the board shall direct the operator to give the advocate access to the records or to such portion of the records as the board specifies.

"Stay pending direction

"(4) The advocate is not entitled to access to the records to which the application relates until the board gives a direction under subsection (3)."

Mr Sterling moves that the bill, as reprinted to show the amendments proposed by the minister, be amended to add the following section:

"Request for access to records

"24.1(1) An advocate who wishes access to the records of a person shall make a written request to the operator of the facility, controlled-access residence or program prescribed by the regulations made under this act, as the case may be.

"Refusal

"(2) The operator is entitled to refuse to give the advocate access to the records if the advocate does not have a warrant for access.

"Restriction

"(3) The advocate is not entitled to access to records relating to other persons."

Section 25:

**The Chair:** Mr Sterling moves that section 25 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsections:

"Consent of the commission

"(2.1) The commission shall not consent to the advocate having access to the records unless it considers that there are reasonable grounds to believe that the operator of the facility, residence or program engages in practices that are detrimental to vulnerable persons.

"Notice by commission

"(2.2) The commission shall notify the operator, in writing, if it consents to the access.

"Refusal

"(2.3) The operator of the facility, residence or program is entitled to refuse to give the advocate access to the records if the advocate does not have a warrant for access."

1740

Mr Malkowski moves that the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following section:

"Access to documents of general application

"25.1 An advocate is entitled to have access, for the purpose of providing advocacy services, to any record that is a document of general application relating to the observation, care, treatment or management of persons that is in the custody or control of,

"(a) a facility;

"(b) a person who operates a controlled-access residence; or

"(c) a person who operates a program prescribed by the regulations made under this act."

**Mr Sterling:** I just want to indicate that I think we will be opposing that very much. It seems to be a wide-open access for the advocate to get any document he would so choose, regardless of having to prove anything to anybody.

**Mrs Sullivan:** I would like to add that we will be opposing that as well.

**The Chair:** Mrs Sullivan.

**Mrs Sullivan:** Sorry, I thought I was recognized.

**The Chair:** Thank you, Mrs Sullivan. Mr Wilson.

**Mr Jim Wilson:** Just on that point also, I think that tomorrow we'd like to discuss exactly what is meant by a document of general application and just how far-spread that general application is.

Section 26:

**The Chair:** Mrs Sullivan moves that section 26 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsections:

"Exception, certain records

"(3) Sections 24 and 25 do not apply to authorize an advocate to obtain the following records relating to one or more vulnerable persons:

"1. Information compiled or documents prepared and used for the purpose of, or in the course of, medical or health education.

"2. Information compiled or documents prepared and used in a course of study, a program, an investigation or in research carried on by or in respect of a facility.

"3. Information compiled or documents prepared and used for the purpose of improving hospital care, medical practice or health practice.

"4. Records relating to complaints made to a college that regulates a health profession.

"5. Information relating to persons other than vulnerable persons.

"Further exception

"(4) An advocate may have access to records described in paragraph 4 of subsection (3) with the consent of the person making the complaint."

**Mr Sterling:** The Liberal critic and myself seem to have engaged lawyers of the same firm or people who have very like minds. I'd like to withdraw my amendment, because it's almost identical to Mrs Sullivan's.



## Section 28:

**The Chair:** Mr Malkowski moves that clause 28(1)(a) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "or subsection 25(1)" in the third line and substituting "subsection 25(1) or section 25.1."

## Section 34:

**The Chair:** Mrs Sullivan moves that clause 34(1)(a) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"(a) who is exercising a right of entry to a premises under the authority of a warrant for entry."

Mr Malkowski moves that section 34 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Entry to private dwellings

"(2.1) Subsection (1) does not apply to a person who refuses to allow an advocate to enter a private dwelling without a warrant for entry."

Mrs Sullivan moves that subsection 34.1(2) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "\$5,000" in the third line and substituting "\$25,000."

Mr Sterling moves that section 34.1 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Offence, acting without reasonable grounds

"(4) An advocate who does not have reasonable grounds when exercising a right described in subsection 17(1), 18(1) or 24(2), (3) or (4) is guilty of an offence and is liable, on conviction, to a fine not exceeding \$5,000."

**Mr Sterling:** Those are the information sections I'm referring to.

## Section 35:

**The Chair:** Mrs Sullivan moves that subsection 35(1) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "\$5,000" in the sixth line and substituting "\$25,000."

## Section 36:

**The Chair:** Mrs Sullivan moves that subsection 36(1) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "The commission may, subject to the approval of the Lieutenant Governor in Council, make regulations" in the first three lines and substituting, "The Lieutenant Governor in Council may make regulations."

**Mrs Sullivan:** I believe it's with reference to this amendment that I stood an amendment down earlier.

**The Chair:** Right. That was clause 7(1)(k).

## Section 7:

**The Chair:** Mrs Sullivan moves that clause 7(1)(k) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"(k) make recommendations to the minister with respect to the minimum qualifications, standards and a code of conduct for rights advisers and advocates."

## Section 36:

**The Chair:** Mrs Sullivan moves that subsection 36(1) of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following clauses:

"(g) establishing minimum qualifications, standards and a code of conduct for advocates and rights advisers;

"(h) establishing training programs for advocates and rights advisers;

"(i) establishing disciplinary procedures and measures applicable to advocates and rights advisers who fail to comply with the standards and procedures established under the act;

"(j) establishing an independent review procedure for,

"(i) complaints relating to the commission or to advocates or rights advisers,

"(ii) appeals of or objections to decisions and determinations by the commission or by advocates or rights advisers;

"(k) establishing procedures for reviewing community agencies;

"(l) establishing procedures for reviewing persons who are authorized to provide advocacy services on behalf of the commission."

## Section 37:

**The Chair:** On the government replacement section 37, in the reprint they struck out the whole section.

We need unanimous consent. Do we have unanimous consent? Agreed.

## Section 6:

**The Chair:** We have two replacement motions on subsection 6(1), I believe. Mr Malkowski.

**Mr Jim Wilson:** There is one PC replacement motion.

**The Chair:** Mr Malkowski moves that subsection 6(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Criteria for appointment

"(1) A majority of the members of the commission shall be persons who

"(a) have or have had a physical or mental disability or an illness or infirmity likely to result in a physical or mental disability; or

"(b) are 65 years of age or older."

**Mr Wessinger:** This is a replacement?

**The Chair:** A replacement for the original.

**Mr Wessinger:** There's a problem with the replacement for the original; if you're going to replace it, the word "be" should come out. It should read:

"(1) A majority of the members of the commission shall

"(a) have or have had a physical or mental disability or an illness or infirmity likely to result in a physical or mental disability; or

"(b) are 65 years of age or older."

**The Chair:** Right.

**Mr Wessinger:** So is that accepted then that the "be" has to be removed? Wait a minute. I'm sorry. It was me who read it incorrectly.

**The Chair:** I think we have it. Thank you very much.

**Mr Jim Wilson:** Mr Chairman, will we see a clean copy of that tomorrow?

**The Chair:** I certainly hope so.

Mr Sterling moves that subsection 6(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

“Criteria for appointment

“(1) The commission shall be constituted as follows:

“1. A majority of the members shall be persons who

“i. have or have had a physical or mental disability or an illness or infirmity likely to result in a physical or mental disability, or

“ii. are 65 years of age or older.

“2. At least one third of the members shall be persons who are family members of vulnerable persons, non-professional persons who provide care to vulnerable persons or health and social services practitioners who provide services to vulnerable persons.”

Is it agreed by both the government and the PCs that the original motions are withdrawn and these replacements shall stand?

**Mr Sterling:** Yes.

**The Chair:** Thank you very much.

**Mr Sterling:** I had a motion on section 2 to change the definition of “vulnerable person.” I withdrew one before

and I want to withdraw the second one, which removes the words “and whether actual or perceived.” I withdraw that motion. That was about the fourth or fifth motion that we considered.

**The Chair:** Thank you very much.

**Mr Sterling:** I’d also like to indicate, Mr Chairman, as we didn’t put forward a motion as was done by Ms Sullivan as to the amendments which she was not going to vote for, we will not vote for subsection 3(2). It is our view that the act should not apply to people under the age of 16, period.

**The Chair:** You lost me. Would you please repeat that?

**Mr Sterling:** It is our view that the act should not apply to persons under the age of 16, that those persons are taken care of under the Mental Health Act and the Child and Family Services Act. Those acts were designed and brought to the Legislature with a view of dealing with these issues at that time. This legislation, by introducing advocates into that milieu, is not assisting in that operation or representing vulnerable children in any additional ways.

**Mr Owens:** I move adjournment.

**The Chair:** Mr Owens moves adjournment. All those in favour? Opposed? Carried. This committee stands adjourned until 10 am tomorrow morning.

The committee adjourned at 1755.



## CONTENTS

Monday 31 August 1992

Advocacy Act, 1992 . . . . . J-279

### STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

- \* **Chair / Président:** Cooper, Mike (Kitchener-Wilmot ND)
- \* **Vice-Chair / Vice-Président:** Morrow, Mark (Wentworth East/-Est ND)  
Akande, Zanana L. (St Andrew-St Patrick ND)
- \* Carter, Jenny (Peterborough ND)  
Chiarelli, Robert (Ottawa West/-Ouest L)  
Curling, Alvin (Scarborough North/-Nord L)  
Harnick, Charles (Willowdale PC)  
Mahoney, Steven W. (Mississauga West/-Ouest L)
- \* Malkowski, Gary (York East/-Est ND)  
Runciman, Robert W. (Leeds-Grenville PC)
- \* Wessinger, Paul (Simcoe Centre ND)
- \* Winninger, David (London South/-Sud ND)

#### **Substitutions / Membres remplaçants:**

- \* Brown, Michael A. (Algoma-Manitoulin L) for Mr Mahoney
- \* Eddy, Ron (Brant-Haldimand L) for Mr Curling
- \* Owens, Stephen (Scarborough Centre ND) for Ms Akande
- \* Sterling, Norman W. (Carleton PC) for Mr Harnick
- \* Sullivan, Barbara (Halton Centre L) for Mr Chiarelli
- \* Wilson, Jim (Simcoe West/-Ouest PC) for Mr Runciman

\* In attendance / présents

#### **Also taking part / Autres participants et participantes:**

Fram, Steve, counsel, policy development division, Ministry of the Attorney General  
Perlis, Linda, policy analyst, Office for Disability Issues, Ministry of Citizenship  
Malkowski, Gary, parliamentary assistant to the Minister of Citizenship  
Valentine, Mary Beth, senior policy and program adviser, Office for Disability Issues, Ministry of Citizenship

**Clerk / Greffière:** Freedman, Lisa

**Staff / Personnel:** Hopkins, Laura, legislative counsel



J-17

J-17

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## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Tuesday 1 September 1992

### Standing committee on administration of justice

Advocacy Act, 1992

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Mardi 1 septembre 1992

### Comité permanent de l'administration de la justice

Loi de 1992 sur l'intervention



Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
Greffière : Lisa Freedman





### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

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### **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Tuesday 1 September 1992

The committee met at 1042 in committee room 1.

### ADVOCACY ACT, 1992 LOI DE 1992 SUR L'INTERVENTION

Consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervention en faveur des personnes vulnérables.

**The Chair (Mr Mike Cooper):** I'd like to call this meeting of the standing committee on administration of justice to order. Today we will be continuing with the clause-by-clause on Bill 74. We'll revert back to the very beginning now and start voting on some of the amendments.

Section 1:

**The Chair:** The first amendment is on government reprint on clause 1(b), and we have an amendment, a Liberal motion, on subclause 1(b)(ii). Are there any comments or questions? Mrs Sullivan.

**Mrs Barbara Sullivan (Halton Centre):** I provided the comments on this in our discussion yesterday and I don't think I have anything to add to that. I think the members will recall that. This is the "reasonable grounds" addition.

**The Chair:** Thank you. Further comments or questions? Mr Malkowski.

**Mr Gary Malkowski (York East):** The government feels that this certainly is an acceptable standard. It conforms with subsections 17(1), 18(1) and 24(2), (3) and (4), so we have no problem with that.

**The Chair:** Thank you. Further questions or comments? Seeing none, all those in favour of the motion by Mrs Sullivan? Opposed?

Motion agreed to.

**The Chair:** Now back to the government motion on 1(b), as amended. Comments, questions? Seeing none, all those in favour of the government motion? Opposed?

Motion agreed to.

**The Chair:** Now on a motion by Mrs Sullivan on clause 1(f), comments?

**Mrs Sullivan:** Once again, I spoke to this yesterday. This is the addition of the words "rights and needs" in the amendment and I believe that yesterday we had an indication of concurrence both from the government and the third party.

**Mr Malkowski:** We are unable to support this because we feel it would encourage support for the rights and needs of the vulnerable individuals. That means that the "needs of a person" may take priority over that individual's actual rights.

**Mrs Sullivan:** I suppose that's one of the reasons this amendment was put forward. I want you to note that it's

within a section that reads, "to acknowledge, encourage and enhance individual, family and community support," and it would then read, "for the rights, needs, security and wellbeing of vulnerable persons."

The addition of rights and needs to that amendment we believe strengthens it and in fact ensures that the family will also be supportive of encouraging and enhancing the rights that are available to the vulnerable person, as well as the needs, which may be health needs, which may be needs with respect to other advice in relationship to property, which may be needs for personal care. We feel this adds to support for the vulnerable person rather than detracts from it.

**Mr Malkowski:** The reason we find this difficult to support is because when we look at needs, we may then find that people would force treatment, it could be disempowering and in fact things could be done under duress.

**The Chair:** Further comments? Seeing none, all those in favour of the Liberal motion? Opposed?

Motion negatived.

Section 2:

**The Chair:** On the Liberal motion on section 2, comments?

**Mrs Sullivan:** I have a replacement motion, which is now being distributed. It's identical really to the section 2 I moved yesterday but deletes clause (c). Do I have to read it back into the record?

**The Chair:** Yes.

Mrs Sullivan moves that the definition of "vulnerable person" in section 2 of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"'vulnerable person' means a person who, because of a moderate to severe mental or physical disability, illness or infirmity, whether temporary or permanent,

"(a) is unable to express or act upon his or her wishes or to ascertain or exercise his or her rights, or has difficulty in expressing or acting on his or her wishes or in ascertaining or exercising his or her rights, and

"(b) does not have another person who is appropriate, able and willing to assist him or her in exercising his or her rights, in expressing or acting on his or her wishes or in ascertaining or exercising his or her rights."

Would you care to withdraw your other motion?

**Mrs Sullivan:** Yes, I withdraw the original motion.

**The Chair:** Thank you very much. Comments?

**Mrs Sullivan:** We had a substantial discussion yesterday on this amendment which appeared to have some support. I thought that the recommendation from Mr Wessinger that clause 2(c) be removed because it in fact was a cause for intervention and not a part of the definition was a



useful one, and therefore I've put forward a new amendment that eliminates that particular clause in the definition.  
1050

**Mr Norman W. Sterling (Carleton):** We're very supportive of this, particularly clause 2(b), in really allowing the family its rightful place in terms of representing vulnerable people. In my view, it deals with the situation in fairly strong terms and allows the family almost first right in terms of taking care of its own within the family, and that's why we support this very strongly.

**Mr Malkowski:** We are not able to support this motion for the following reason: In clause 2(c), as mentioned, that definition of vulnerable individual shouldn't include the risk of serious harm to a person. That definition then would impede a person's ability to get an advocate.

**Mrs Sullivan:** I apologize that we don't have the replacement motion in front of us now.

**The Chair:** We do have it.

**Mrs Sullivan:** We do have it in front of us now. So as a consequence, we're not dealing with the original motion. If that is the government's objection, it appears that the replacement motion in fact meets that objection, and I hope to see government support for this amendment.

**Mr Jim Wilson (Simcoe West):** Particularly in light of the discussion we had yesterday around the word "appropriate." I thought through that discussion we alleviated some of the concerns that the government had expressed and that I had expressed yesterday. Today, as Mr Sterling has said, we're certainly very supportive of this motion because we think it's necessary to support families.

**Mr David Winninger (London South):** My concern certainly wasn't alleviated yesterday, and I presented the case where the family member may be entirely appropriate and willing and able to give care, but the vulnerable person chooses not to have that person provide the care. That amendment to the definition would foreclose the possibility of even having an advocate because you've defined such people as not being vulnerable merely because there's a family member in the picture ready, able and willing to provide care.

**Mrs Sullivan:** But they wouldn't be appropriate.

**Mr Jim Wilson:** It wouldn't be appropriate; that was the discussion with the term. Legal counsel advised that the other statutory requirements stand.

**Mr Winninger:** What's appropriate to the beholder may not be appropriate to the vulnerable person. That's the point, empowering vulnerable people to make choices, and that amendment would take the choice to have an advocate away. It would depend upon whether or not the family member agrees. I don't see the need for that, so I'm not convinced.

**Mrs Sullivan:** I believe that in the interpretation provided by the counsel to committee yesterday, the word "appropriate" was defined to include requirements of other sections of various bills, such as where the person has made a choice with respect to a power of attorney. "Appropriate" would also include the decision-making of the vulnerable person himself as to the involvement of the person.

"Appropriate" would mean that a person might be appropriate at one time and another person appropriate at another time. We think that the use of that word in fact meets the criterion of objection that's being put forward by the government members.

**Mr Malkowski:** Again I'm going to have to disagree, because the principle we're dealing with here is freedom of choice and autonomy that has to be respected for each individual.

**Mrs Sullivan:** And that's precisely what this does. The word "appropriate" enables the person to provide that choice.

**Mr Sterling:** Would it be more acceptable to the governing party if in addition to "appropriate" the word "acceptable" were included in there? It would surely mean to me that it would be an acceptance on the part of the vulnerable person that the family member was representing him.

**Ms Jenny Carter (Peterborough):** The person might need an advocate in order to determine whether somebody who was acting for him was in fact acceptable to him from his own point of view. This is the point that we can't underline too much.

**Mr Sterling:** So you're saying that even though the vulnerable person wanted the family member, who was acceptable to him, and it was appropriate and the family member was able and willing, the state should intervene regardless?

**Ms Carter:** But who is to say whether that person is acceptable to him? It may be that he needs to be able to say that to a third person.

**Mr Sterling:** The vulnerable person?

**Mrs Sullivan:** Why should the government say? It should be the person who says.

**Ms Carter:** It should indeed, but he may need to be able to say that to an advocate in order to get through some barrier of being protected by people whose protection may be suppressing his own wishes.

**Mr Malkowski:** I think we're back to the term changing to "acceptable." Again, that is open to interpretation on acceptable to whom. If we're talking about the vulnerable individual himself, his choice of yes or no is what should be respected and followed.

**Mr Paul Wessinger (Simcoe Centre):** My concern about the amendment is that if it were made and then you look at clause 1(b) of the act, it somehow that provision somewhat unusual or not making sense, because to provide advocacy services, for instance, "to help vulnerable persons to bring about systemic changes," it would not make sense to say you're only acting for—I think clause (b) doesn't really belong in the definition of "vulnerable person"; that's what I'm saying. It would make the rest of the act not very consistent, and the same rules reply to (b) as reply to respect to risk of harm. From a purely legal point of view, I think this amendment would create problems in the whole act. That's why I think it's inappropriate; it should be in section 7.



**Mrs Sullivan:** Let me provide you with an example. A person has had a stroke and is unconscious or, in the aftermath of the stroke, is having difficulty expressing himself and is also having difficulty in dealing with the facility in which that person is located or with other aspects relating to care. A family member will be downgraded if the government's description of a "vulnerable person" is taken into account in terms of providing advocacy services to that person, unless this amendment is included. An advocate will have priority in assisting the stroke victim—he certainly will—to obtain rights, to obtain information, to express himself and to have his wishes acceded to.

I think it's very clear that the government's intention in not accepting this amendment is to downgrade the role of families and of friends, and to replace the involvement of those people with basically government advocates, and we just do not believe that's acceptable.

1100

**Mr Malkowski:** In responding to that issue, if we look at section 15.2, it says, "An advocate who is providing advocacy services to a vulnerable person under clause 7(1)(b) shall, if feasible" and then goes on to say "(a) consult with the vulnerable person to ascertain whether there are family members or friends who may willing and able." That responds to that very concern.

**Ms Carter:** I think we've got a real misunderstanding here. The point is, if somebody's vulnerable and in the situation Mrs Sullivan is describing, the family and friends obviously will assist and he won't need an advocate. Why should they? An advocate is only called in if needed.

**Mrs Sullivan:** Then they are not vulnerable.

**Ms Carter:** They're still vulnerable, they're defined as vulnerable, but they wouldn't need an advocate. So this is in the wrong place. We don't want to remove that person from being defined as vulnerable, because in his situation it may be that the family and friends were not adequate in some way and he might need an advocate. In most cases they would not, they would not call on an advocate's service, but that doesn't mean they should be defined out of this category.

**Mr Sterling:** I just want to say that unless some of the later amendments are accepted—and we don't know whether they will be—it's the advocate who determines who's vulnerable and who's not. There doesn't appear to be any appeal mechanism for the vulnerable person to dispute what an advocate says or doesn't say.

Once the advocate says Joe Blow is vulnerable, then that advocate can start to exercise powers like getting information about Joe Blow, without any kind of check on those particular powers. That's what I think some of the section homes in on.

In some ways, because there are so few checks and balances on what an advocate does—according to the bill as it's now written, he doesn't have any disciplinary process whereby people could complain about his activity. If he gets information about a particular patient and is careless with that information and it falls into the hands of other people, there's no penalty against that advocate. That's why we are putting forth a number of amendments to keep

the advocate in check, because he or she is put in a very powerful position over the person he deems is vulnerable.

**Mrs Sullivan:** I'd like to stand this amendment down for the time being and come back to it in our discussions at a later point.

**The Chair:** Do I have unanimous consent to stand this one down? Agreed?

**Interjections:** Agreed.

**Mr Malkowski:** To respond to Ms Sullivan's concern, also in subsection 18(3) it clearly says, "The advocate must leave the premises promptly if the vulnerable individual indicates that he or she does not want the services of an advocate." That clarifies any concern.

**The Chair:** All right. This motion's been stood down.

**Mr Malkowski:** No, I would like to call a vote.

**The Chair:** It's already been stood down. They agreed. I asked for unanimous consent to stand it down and everybody agreed. There was no disagreement.

**Mr Malkowski:** I did not hear that call.

**The Chair:** I looked around the room when I called it and there was no disagreement.

Section 3:

**The Chair:** Now we move on to the government re-print on subsection 3(2), government motion.

**Mr Sterling:** Yesterday I indicated that we would be voting against subsection 3(2) to be part of the bill. My reasoning is twofold.

The Advocacy Commission, basically, is made up of people who represent adult interests. It appears that the act, by subsection 3(1), is basically dealing with vulnerable people who are 16 years of age or older.

We have heard testimony here that there are problems in terms of dealing with adolescents who may be considered competent but have lack of experience to make reasonable decisions with regard to their care and control. We've also heard significant evidence from various groups who have talked about our Child and Family Services Act. We've heard evidence about our existing Mental Health Act as well.

It's my view that under Bill 109 there is a capacity with the Ministry of Health to not only use advocacy rights advisers but other people as well. It seems to me that advocacy for young people would be better practised outside of the Advocacy Commission. I don't think the structure of the Advocacy Commission, as it is set up, will properly represent the views of vulnerable children or people under the age of 16. As we see, the commission is to be made up of people with a mental or physical handicap, former or future. It's to be made up of people who are over 75 years of age etc.

My feeling is that we would be best served and that people under the age of 16 would be best served if we dealt with them in a separate category altogether under Bill 109 in terms of rights advisers; that we in essence let the common law prevail up to the age of 16, and that rights advisers be provided by the Ministry of Health as they would see fit, in conjunction with the Child and Family Services Act and the Mental Health Act, so that those children can



have adequate representation if they are in fact being kept against their will. I believe that under the Mental Health Act there are review procedures when children are kept in those particular circumstances.

If it is felt that there should be additional advisers, I just don't think the Advocacy Commission is the place for this particular group of individuals to be represented. That's after I've heard all of the evidence before us. I really do hope the government will try to keep things in perspective in terms of the evidence we've received.

1110

**Mr Winninger:** I'm cognizant of the concerns expressed by Mr Sterling. At the same time, I'm mindful that when Mr Giuffrida of the Psychiatric Patient Advocate Office was here responding to the amendments, he indicated his concern that advocacy services that are presently provided to children would be foreclosed on if we were to adopt the restrictive provision under the Advocacy Act. I know that was his concern: that services presently provided to children could no longer be provided if there was an age 16 cutoff.

**Mr Sterling:** Well, how are they being provided now without an advocacy act? That's my question. I assume that they can continue to be provided but not under the Advocacy Commission, and that would be what I would recommend that would take place.

**Mr Winninger:** Well, yes. For example, children under the age of 16, because of a certain provision in the Mental Health Act, are receiving some advocacy and rights advice right now. Maybe I can get some more advice from staff on this through the auspices of the patient advocate office. Mr Giuffrida made the point that if we had an age-of-16 cutoff, that couldn't happen. I would like to hear from staff on this point too, if they're willing to elaborate on that concern.

**Ms Mary Beth Valentine:** I think there are two separate issues. One is the issue of rights advice and one is the issue of advocacy, and I think Mr Giuffrida was referring to general advocacy for children under 16, as well, that is now provided in provincial psychiatric hospitals.

The simple response to the issue of rights advice, as it's now provided in other facilities, is that there is the intent that advocacy that is now provided elsewhere will be transferred to the commission once the commission is operational, so in fact it would all come under the same auspices at that point.

**Mr Winninger:** Which would exclude children under the age of 16 if it came under the same auspices?

**Ms Valentine:** If the requirements are still there or there in any act for rights advice, then rights advice would be provided by the commission. In effect, it may well be provided by the very same staff people who are now providing it, but the authority would then be the commission versus simply the authority of the Psychiatric Patient Advocate Office under the Ministry of Health at this point.

**Mr Wessinger:** I'm wondering if the committee would like some clarification as to what rights are provided under the Mental Health Act in this matter.

**Mr Jim Wilson:** Just before you do that, in that answer you're obfuscating rights advice and advocacy services. I think Mr Winninger wanted to know about advocacy services for those under age 16.

**Ms Valentine:** Yes, that is a different issue. The issue is that currently in the provincial psychiatric hospitals, where advocacy has been provided for approximately 10 years, there are two psychiatric hospitals that have adolescent units that serve about 100 children, adolescents, who are now receiving general advocacy services. As this bill goes through, the commission will not be providing advocacy for those children.

**Mr Wessinger:** I guess they'd like that information. If you'd like to clarify it for the committee, the situation with respect to what rights are presently provided under the Mental Health Act.

**Ms Valentine:** Let's first of all comment to the—

**The Chair:** Excuse me. Could you go to a mike that's working?

**Ms Valentine:** Oh, here it is. The particular units in the psychiatric hospitals that now have access to the PPAO services, they are actually quite a complex situation under legislation because, although they are currently under the Mental Health Act, that's by way of exception temporarily by regulation because those particular units are in fact under the Child and Family Services Act. However, there are discussions between the ministries of Health and Community and Social Services as to the ultimate provision of where those units would fall, since they are units in which children are served.

As to rights advice, the actual service delivery of rights advice under the Mental Health Act is, for a variety of reasons, in addition to the capacity to consent to treatment. There is, of course, the issue of involuntary committal, there's the issue of access to your own clinical records, there's the issue that for under-16s you have an ability to rebut a presumption of incapacity to consent to your own treatment. If you've been admitted on parental consent as a non-involuntary patient—in other words, you don't meet the committal criteria—there's an ability to challenge that finding.

For all those reasons, there is an ability to meet with a rights adviser, and that rights advice is delivered in the provincial psychiatric hospitals under the patient advocate program by rights advisers who work under the supervision of the advocates. In other hospitals, general hospitals, psychiatric units and so on, the rights advice is delivered by duty counsel under legal aid. I think the feeling is generally that that's not been the most satisfactory arrangement because it doesn't have the kind of coordination the patient advocate program is able to provide.

**Mrs Sullivan:** Thank you. I think we really are dealing with two issues here. Mr Sterling has raised one issue with respect to the provision of the rights advice. The issue relating to the children's units under the Psychiatric Patient Advocate Office is one we have had concern about. The young people who are there who are receiving advocacy services are used to receiving services and have built relationships with advocates who are working with the PPAO.



We've heard a lot of intention with respect to the place of the PPAO. We see nothing in this legislation in any place that shows in fact how that will fold into a new advocacy system. There's nothing in the legislation that causes that, and there's no provision for grandfathering those youth units.

We understand that Bill 74 generally applies to people over 16 and that it's not the policy intention of the government to lower the age limit for the provision of advocacy services.

None the less, the question I want to ask is, does subsection 3(2), which indicates that the act also applies in respect to other persons, capture the young people who are already receiving advice, advocacy services, through the PPAO? If it doesn't capture them, one would assume that an entirely new arrangement for those young people is going to have to be made, either through legal aid or through another service provision, and in those cases one assumes that they will not be at all subject to this act. I wonder if we could have some understanding of why the government doesn't want to grandfather those two units, which are being served by the PPAO now, and where in fact the PPAO is going to fit in terms of advocacy services. This is an age issue, but there's another issue involved there too.

**The Chair:** Comments?

**Mr Sterling:** Yes. When I heard the explanation with regard to how people under 16 are being treated in our province now, it made me even more convinced that we shouldn't vote for subsection 3(2). That is because of the intermeshing of the various pieces of legislation we already have in place, the Child and Family Services Act and the Mental Health Act.

Secondly, I view the whole area of decision-making somewhat differently for people who are 16 years of age or more, if that is the defined age we're going to choose. If an adult, if we want to say 16 years of age or more, wants to make a decision to not receive treatment in the health care setting etc, we are deciding to empower that person with the right to make that particular decision. However, I believe that society as a whole owes an obligation to people under 16 to encourage them perhaps to a greater degree to follow the advice of the people we entrust to provide treatment for those individuals.

That's where I see the Advocacy Commission and the Consent to Treatment Act as being very different for those two bodies in society that we as politicians are supposed to represent. I really, truly believe that the commission—and this issue has not been addressed—will not focus on what is a reasonable balance between the right to treatment for young people as opposed to the right of empowerment for those young people. Therefore I believe that whole body of individuals, those people under the age of 16—because I think we have to pick an arbitrary age—should be dealt with differently and away from the Advocacy Commission. I do not believe the Advocacy Commission will represent those people as we as politicians should view our duty to that segment of our society. That's why I continue to put forward the idea of having the Advocacy Commis-

sion truly represent people 16 and over, and under Bill 109 I hope that the Minister of Health would capture the advocacy services which are being provided to people who are under 16.

1120

**Mr Malkowski:** Mr Chairman, could we clarify something?

**The Chair:** Go ahead. It's for clarification?

**Ms Valentine:** I can clarify further, if you like.

**The Chair:** Sure.

**Ms Valentine:** At one point, there was a suggested amendment though the Minister of Citizenship to grandfather the children and adolescents who are now receiving advocacy services to allow them to continue until they're with some other system in place, if at some point that happened. However, there was discussion at the cabinet committee on social policy, and the decision taken at that level was that services should be provided through the Child and Family Services Act, the same as they are provided or not provided for children in other settings. So it has been a decision regarding general advocacy services that was taken at that level.

**Mr Sterling:** I'm sorry, I don't follow the reasoning behind that. What is the decision?

**Ms Valentine:** That services should be arranged through the Child and Family Services Act, the same as for adolescents in other settings. In other words, children in other settings do have some advocacy services available to them through the Child and Family Services Act. There are three advocates for the province. It's an entirely different type of setup, but other than for issues of rights advice, that general advocacy should be provided in the future through the Child and Family Services Act versus through the commission.

**Mr Sterling:** So you're supporting what I'm saying, is that right?

**Ms Valentine:** Everyone's shaking their head at me. I'm not entirely sure because I've been in other discussion here, but I'm stating what the CCSP decision was at the time.

**Mrs Sullivan:** I think that there is agreement between Mr Sterling and the counsel to the committee, or the policy adviser to the ministry, but I wonder if we could have some clarification of what in fact will happen to the PPAO and other services that now exist and how that's accounted for in this bill. I think this is the appropriate place to do it.

**Ms Valentine:** Again, I can clarify that there has been a cabinet decision that the PPAO will be transferred to the commission once it is operational.

**Mrs Sullivan:** But the point is that that is not included in this bill, nor in Bill 110. As far as I know, they are now authorized under the Mental Health Act to act, and there's no provision for that kind of transfer.

**Ms Valentine:** Under the Mental Health Act at this point it's because of the section 5 authority—it's actually now section 9 in the new revised act—which is similar to an inspector's authority that's granted by the minister, so that the minister would make the decision. Basically, it would



be a ministerial decision to transfer the program rather than grant a specific certificate, which they now have.

**Mrs Sullivan:** But the Minister of Health isn't responsible for the Advocacy Act. Specifically, the Minister of Citizenship is responsible for it. The Minister of Citizenship would not have the authority to transfer that program.

**Ms Valentine:** No, the Minister of Health has made the commitment to transfer the program. It has been a cabinet decision.

**Mrs Sullivan:** I don't think that's good enough. I just don't think that's good enough.

**Ms Valentine:** It's only an administrative issue. The PPAO is not a legislated, mandated service at this particular point. It's only basically at the whim of the minister that section 5 authority has been granted to the advocates. That has been one of the concerns actually for the lack of the authority of the advocate program to date. It is strictly an administrative function.

Perhaps when Gilbert is here this afternoon, or at some point, he might be able to address it and clear it up for you a little bit. But it is strictly an issue that the minister makes the appointment and, quite frankly, Gilbert issues the certificate. It's generally an inspector's type of certificate for psychiatric facilities. There is no legislated authority for PPAO at this point.

**The Chair:** Seeing no further discussion, all those in favour of the government motion on subsection 3(2)? Opposed?

Motion agreed to.

Section 4:

**The Chair:** The Liberal motion on section 4, Mrs Sullivan.

**Mrs Sullivan:** Although this isn't a motion relating to substance of delivery of services and so on, I really feel that it's in the interests of the government members to support this particular motion.

The act now requires that the minister responsible for Bill 74 is the Minister of Citizenship. It's designated completely. As I indicated yesterday, this is a very practical amendment to ensure that if there's a change in a structure of government, in the duties that are required of a minister, or even in the name of the ministry itself, the bill does not have to be reopened to make another change with respect to the minister who is responsible for the act.

This is, I think, a useful and highly practical amendment. We don't see any reason for not proceeding with it, because it's very clear that, with this government, the Lieutenant Governor in Council would designate the Minister of Citizenship, assuming that there's always going to be a Minister of Citizenship with this government.

If there are melded responsibilities of a minister, it may be less useful for that ministry and that minister to have responsibility in perpetuity. We just feel that this is a very practical amendment and should be considered by the government.

**Mr Malkowski:** In general, we find this motion acceptable. However, there may be similar adjustments that would then have to be made to other sections.

**Mrs Sullivan:** I have amendments to account for that.

**Mr Winninger:** I would suggest the matter be stood down.

**The Chair:** Do we have unanimous consent to stand this one down? Agreed.

1130

Section 5:

**The Chair:** Next, the Liberal motion on subsection 5(2).

**Mrs Sullivan:** Mr Speaker, I have a replacement motion for this section.

**The Chair:** Would you care to withdraw your original?

**Mrs Sullivan:** I'd like to withdraw my original motion, subsection 5(2).

**The Chair:** Mrs Sullivan moves that subsection 5(2) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Composition

"(2) The commission shall consist of a chair and at least nine and not more than 12 other members, appointed by the Lieutenant Governor in Council on the minister's recommendation."

**Mrs Sullivan:** Mr Speaker, this motion is put following our discussion with respect to another motion that I put to amend subsection 6(1). With respect to the composition of the commission, the discussion yesterday, it would seem to me, came to the conclusion that the requirement I had included in the original motion of a solid 12 members plus a chair for the committee was in fact an impractical one and that a sliding recommendation of not less than nine, not more than 12 would be appropriate to capture the various representatives of organizations and individuals whom we want to see represented on the commission. In consequence, I'm putting this motion forward. I hope it will be considered by the government on its own and certainly as part of a companion of my later amendment.

**Mr Jim Wilson:** We will be supporting this amendment.

**Mr Malkowski:** We will not be able to support this motion, because the requirement that there shall be a chair and a specific number of members does not allow for sufficient flexibility for the realities of finding appropriate replacement candidates.

**Mrs Sullivan:** I need more justification of that response, because the recommendations for the makeup of the commission now are that the commission shall include a chair, at least six and not more than 12 other members. My change would be a chair, at least nine and not more than 12 other members.

**Mr Malkowski:** I think it has to be read in context with subsection 6(1), since the basic issue is the intention to add family members, which is something that we would have to decline.

**Mr Sterling:** I'm sorry, I don't understand that last comment. Perhaps I could have some amplification of it.

**Mr Malkowski:** Reading it in context, looking at subsection 6(1), the basic issue seems to be that the intent is in fact to add family members to the commission, which is something we would not be able to support.

**Mrs Sullivan:** Mr Chairman, we're dealing with subsection 5(2), which suggests that the commission now be reconstructed from a minimum of six to a minimum of nine people and a maximum of 12, which is exactly what the commission is comprised of now, and the chairman. This motion as presented should be dealt with separately from any other later motions. It stands by itself. In fact it will require a minimum size of a commission that is larger than that proposed by the government, but only minimally larger. I don't see what the big deal is.

**Mr Michael A. Brown (Algoma-Manitoulin):** In reading this, I'm a little confused when I read subsection 6(1) as reprinted, which tells us, "A majority of the members of the commission shall be persons who are or have been vulnerable persons."

I'm confused on just a basic numbers game. How does this work if there are resignations on the board, if in fact the board changes? How can you ensure, with a flexible number of people on the board, that the majority is maintained? If in fact the wrong people resign in terms of quota, what happens to the majority and therefore what happens to the legal ability of the board to act? I wonder if the ministry could help us with that.

**Ms Linda Perlis:** The section as it's now drafted provides for a flexible number, six to 12, as opposed to the new proposed nine to 12, so there is the same degree of flexibility. There is also the provision in subsection (5) for the Lieutenant Governor to appoint a replacement. So there are mechanisms within the section to address the concerns you've raised.

**Mr Brown:** I understand that, but Mr Malkowski indicated to Ms Sullivan that the difficulty with going to nine was the difficulty with replacements and that often just the practicality of doing that takes some time. So the practicality of dealing with replacements, whether it's six or nine—

**Ms Perlis:** Can I just interrupt for one sec? I think, in fairness to Mr Malkowski, he hadn't yet seen the replacement motion and he was speaking to the original motion and that's what the source of the confusion is. Mr Malkowski was attempting to respond appropriately to the original motion, which stated that there be a fixed number. He hadn't yet seen the replacement motion, which provided for the sliding nine to 12.

**Mr Brown:** It's sliding six to 12 in the—

**Ms Perlis:** Correct.

**Mr Brown:** I'm just having a little trouble. I understand the difficulty with replacements, and the point you made is well taken. What happens if the wrong people on the board, for whatever reason, withdraw from the board? The majority is then in question. I'm not particularly talking to Ms Sullivan's.

**Ms Perlis:** I understand.

**Mr Brown:** It doesn't matter which one you use, you've got the same problem. Does the board then lack legislative authority because it lacks the appropriate majority? That's the question I'm putting to you.

**Ms Perlis:** I'll have to seek some advice on that. I'm not entirely sure of the answer at the moment. I can come back to you with an answer to that.

**Mr Jim Wilson:** Perhaps now that Mr Malkowski is looking at Mrs Sullivan's amendment we could have the government's comment again, because legal counsel just indicated his comments were directed to the original.

**Mr Malkowski:** Perhaps at this point further discussion needs to take place, so I would recommend we stand down this motion.

**The Chair:** Do we have unanimous consent to stand this one down? Agreed.

The next one is the Liberal motion on subsection 5(5).

**Mrs Sullivan:** Mr Chairman, I'd like to withdraw that motion.

1140

Section 6:

**The Chair:** The next one will be the government motion on subsection 6(1).

**Mr Brown:** So we don't waste a lot of time, can we stand this one down as we wait for a discussion of the previous motion that was just stood down, subsection 5(2)? They obviously interrelate.

**Mr Winner:** No they don't. Your own members agree that there should be a majority.

**Mr Brown:** The only question I have is that given the point I just made—and we don't know the answer to that—it may be that the wording of this section has to have some additions to it. I'm not objecting to the section, other than to say it may need a little work to be massaged to make subsections 5(2) and 6(1) work together, and the decision on subsection 5(2) hasn't been taken. I'm not objecting to the principle; I'm just objecting to the workability.

**Mr Winner:** What did your notes say?

**Mr Brown:** You don't want to know.

**Mr Stephen Owens (Scarborough Centre):** Let's share the humour over here.

**Mr Winner:** My point is that the majority of the members being vulnerable persons is unaffected, in my view, by whatever we do to subsection 5(2). The majority will still remain supreme, so I'm not sure why we'd need to stand that one down.

**Mr Jim Wilson:** We don't. Let's keep going.

**The Chair:** Okay. We're on government replacement motion on subsection 6(1). Any comments?

**Mr Malkowski:** The original subsection 6(1) motion is withdrawn. We're discussing now the government's replacement motion, right?

**The Chair:** Which was moved yesterday.

**Mr Malkowski:** All right, fine.

**Mr Sterling:** This motion has been moved. Basically the government is now saying that the majority of the commission shall be persons who have a physical—I'm paraphrasing a bit—or mental disability or an illness or infirmity likely to result in a physical or mental disability, or they are 65 years of age or older.



I don't think we can discuss these motions in isolation. I have put forward an amendment, and my motion was tabled yesterday as well, which would add to that a second clause which would guarantee that one third of the members would be family members of vulnerable people, non-professional groups who provide care to vulnerable persons—

**Mr Wessinger:** On a point of order, Mr Chair: I'd like some clarification, because we're on government amendment 6(1), and there's also a PC motion 6(1) and a Liberal motion 6(1), alternate 1 and alternate 2. Perhaps the clerk could indicate whether we're doing them in the right order.

**Clerk of the Committee (Ms Lisa Freedman):** The order we're going to do them in is, first, the government replacement motion.

**Mr Wessinger:** That is the proper order.

**Clerk of the Committee:** Right. If that passes, we will then proceed with the PC motion. If that passes, we may then have to rewrite the Liberal motion before we can consider that. But that will be the order: the government replacement, PC, then Liberal motions to that section.

**Mr Jim Wilson:** Because our motions deal with the reprint.

**Mr Wessinger:** I'm sorry. I was under the impression that on previous occasions we've dealt with opposition—

**The Chair:** I agree this is a little difficult, and we'll try to sort our way through this. Further discussion.

**Mr Malkowski:** Focusing on the government replacement, I just want to make sure we are clear now and that we know which motion we're dealing with.

**The Chair:** Yes we are. Comments?

**Mrs Sullivan:** Like Mr Sterling, I have difficulty—I know this is a strange process we're going through—in dealing with the government motion in isolation from the recommendations that have been made by others.

I applaud the government for assuring that on the commission there will be at least some representation from people who are over 65. Clearly, this is a component of our population which has a high level of vulnerable people, and I think that's useful. None the less, given the complexity of the makeup of the commission, this could mean there is only one person on a maximum 12-member commission who is over 65 and who is vulnerable in one category—or who may not be vulnerable, depending on where he fits into the quotas—or disabled in those areas.

It seems to me that it would be useful to look at the recommendation I've put forward before we accept the government's amendment, which makes a minimum requirement of at least two members of the commission who are 65 years of age or older, in which case there is a place that's continuing, that's understandable. We know the majority of the members of the commission shall be people who have had a physical or mental disability.

I think we virtually all agree with that first criterion, to ensure that there is a broad representation, given the nature of areas in which senior citizens may be vulnerable. I think it's useful to have a stronger statutory representation for

seniors. I don't think the government's motion does that for us. I would prefer to see two members who are guaranteed to be over 65 years old sitting on the commission.

**Mr Jim Wilson:** In our discussion on section 5, I think it was Mr Malkowski who indicated that the government would not be amenable to any family members on this commission. That's the crux of both the Liberal and PC amendments, so I think we should clear the air right now. I want to know why the government is so opposed to having family members on this commission.

1150

**Ms Carter:** The answer to that is very simple. The main point and thrust of this legislation is to empower vulnerable people, and we are watering down that principle if we have family members or care givers on the commission. As I pointed out yesterday, we are having an advisory committee on which those people may be represented. But I think any backing off on our part on the composition of the commission itself would be seen as a betrayal of the people we are trying to represent, and I think rightly so. Also, the government motion does leave the way wide open for there to be two or more persons over 65 on the commission, so I don't see any problem with that.

**Mrs Sullivan:** I can't tell you how specious I believe the government's arguments are with relation to the inclusion of organizations that represent family and friends of vulnerable people; a minimum number, outside of the majority who are or have been disabled. It's ludicrous to me to think that the government believes that families and friends and organizations which are set up as support groups for vulnerable people do not understand the issues associated with the vulnerability, the very practical issues associated with housing, with vocational services, with health care delivery, and are not dealing with those issues on a daily basis in association with and as part of the lives of people who are part of their families or part of their community and who are vulnerable. It is just absolutely incomprehensible to me that the government believes that families should be so excluded from the decisions of a commission which is set up to assist people in making their own way and in receiving advocacy services. It is absolutely downright ludicrous that the government is proceeding in this way, and that it does so by saying: "We can't accept families. We don't believe families have a place in decision-making or participation in the work associated with empowerment of vulnerable people." That is sheer nonsense.

**Mr Winner:** I was just going to comment, in addition to the remarks of Ms Carter, that the legal text does not exclude family members from serving on the commission, whether Alzheimer's or Friends of Schizophrenics. They're not specifically excluded, so to say that they are specifically excluded is specious in itself.

**Mrs Sullivan:** The point is that they are not specifically included, and the words we have heard at this table, not only today, but yesterday and previously, indicate that there is an antipathy to the participation of organizations representing the family and friends of people who are



vulnerable. That is very clearly the policy direction of this government. You don't trust families and you don't trust friends.

**Mr Sterling:** Ms Carter's statements really bother me, because basically what she's told the committee today is that it's not a majority of the committee that is to be made up of people with physical or mental disabilities or an illness or 65 years; it's all the committee. It's not a majority any more; it's all the committee. So what we're doing in the opposition is trying to determine what in fact is the intent of the government. If the intent of the government is to have all of the commission from this group of people, well, then say it. Let's say all of these people are that way.

My amendment says that the majority of them or up to two thirds would be from this group of individuals, and the other third would be from the people who will be required to provide the services in general and are closely associated with vulnerable people in another manner.

Now, if you want to set up the commission so that it is always fighting with the advisory committee, then I suggest you put all members of the commission from the one side and all the people on the committee from the other side, if you want them fighting like cats and dogs as we proceed in setting up this commission. Because that's what you'll get.

It seems to me that the most reasonable thing for the government to do in setting up this commission is to give the bias, of course, towards those people who are affected, give them empowerment in terms of the commission, give them two thirds of the seats. But on the other hand, guarantee the families, guarantee the providers one third of the seats, so that when the commission makes its ruling, it will hear the other side. When they're drawing the rules, when they're drawing the code of ethics, they will have that expertise at the table of people who are on the ground and are in fact going to be required to live with what the advocates will be going out in the field and doing.

I can't understand Ms Carter's suggestion that all these people should be from the one group, and that is what she said to the committee a few minutes ago. If that is not the case, then there should be no reluctance on the part of the government to at least guarantee that one third of the panel come from the other part of the issue.

**Mr Malkowski:** There are two points I'd like to clarify. You've been talking, first of all, on the issue of, we have to look first at the advisory committee. The whole appointment to the commission comes from nominations as well, so there's nothing that will stop a group from nominating a family member. What's important is that the vulnerable individuals themselves are choosing their own representatives to sit on the commission, and that's how the appointment process is set up.

**Ms Carter:** I think my point is similar to Mr Malkowski's, that we all know that the appointment is set up in section 13 and that eight of the appointments are decided by these designated groups and that, as Mr Malkowski said, there is no limitation placed on whom those groups may select. So if I gave any impression to the contrary as to the actual final composition of the commission, then I

would like to withdraw anything that would lead to that impression. The point is that it's the advisory committee that picks the nominees, and I believe the minister has three appointments.

**The Chair:** Further comments? Seeing no further comments, all those in favour of the replacement government motion on subsection 6(1)? Opposed? All members have to vote. Mr Winninger, you didn't vote.

**Mr Winninger:** I am sorry, I was reading. I'm voting in favour of the government's substitute motion.

Motion agreed to.

**The Chair:** Noticing the time, is there anybody who would like to move recess for lunch?

**Mr Jim Wilson:** Could we finish the section, Mr Chair?

**Mr Sterling:** Perhaps it would be more appropriate if I could go next, because mine tails immediately on to the other one.

**The Chair:** Mr Sterling moves that section 6 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"(1.1) At least one third of the members sons who are family members of vulnerable professional persons who provide care to persons or health and social service practitioners who provide services to vulnerable persons."

**Mr Sterling:** I'm adding to the government motion, which was just approved a minute ago. I think my motion is self-explanatory. We have just voted that the majority of the members of the commission will be people who have or have had a physical or mental disability or are 65 years or older. My motion only secures the other part of the equation in the makeup of the commission, and that is that one third of the board be made up of the other side of the equation, so that if there are six members, two members would be from the other part, if there were nine members, three members would be from the other part, and if there is a full board of 12 members, you would have four members from the other part.

1200

I think this motion should be supported in order to give the commission a balance, I guess, at the commission table, to reach decisions which are heavily weighted in favour of the bias that they're supposed to have but that will also be fully cognizant of the other arguments by the people who have to serve the advocates who are out in the field. I think it would assist the commission in being successful in meeting its objectives under Bill 74.

**The Chair:** You have withdrawn your old motion?

**Mr Sterling:** Yes. I withdraw the former motion.

**The Chair:** Comments? Mr Wilson.

**Mr Jim Wilson:** I think Mr Malkowski was first, Mr Chair.

**Mr Malkowski:** Sir, as a point of clarification, withdrawing which motion?

**The Chair:** He withdrew the one from yesterday and now has a new motion to cover the previous one.



**Mr Sterling:** Basically, my motion yesterday included what we have just accepted at the committee, so that I could not repeat again or include again what we have already approved, and we just approved that a minute or two minutes ago.

Basically, I am adding to that 6(1) by saying that we have taken 6(1), the government motion that has been passed by the committee, and I am adding to it a rider that a third of the commission should be from this other group. If you refer to my motion yesterday, all you have to do is look at clause 2 and you will get the essence of my amendment to 6(1) as it now stands, passed by this committee.

**Mr Malkowski:** We have already moved an amendment to 6(1) and again, as mentioned, the organizations can nominate family members. Therefore, there may be individuals who are family members who will be nominated and therefore there will be that representation on the commission. So we do not feel there is a need to support this motion.

**Mr Jim Wilson:** I was just disturbed by what Mrs Carter had said earlier in terms of perceiving this amendment—and, I assume, the Liberal amendment—that if they were to accept this commonsense approach to running the commission and to membership on the commission, that would be perceived as caving in, and that vulnerable people would lose the empowerment that this legislation is trying to give them.

I don't think that's true at all. I think that what we're trying to do here is have some assurance, as Mr Sterling has said, that family members will be involved and that non-professionals and other professionals will have an opportunity to be on that commission. Unlike the Liberal motion, which ties the government to two members and two members, this simply gives the government some flexibility by just using the one-third rule. I think it's really a tremendous advantage for vulnerable people that their decisions not be made in isolation, that there be availability to them, on the commission, of the advice and expertise that these other groups would bring to that commission. I think it only makes sense, after all. The government is setting up an arm's-length commission with tremendous powers, unprecedented, and you want to make sure the decisions they make have as much balance and fairness in them as possible. To us, this not only fulfils your obligation and our obligations to vulnerable people but also brings some fairness and some common sense to the proceedings of the commission. I guess it leaves us wondering why you will not support this, I think, very constructive motion.

**Mr Malkowski:** In response to that point, we have listened to the various presentations that have come before the committee, as well as to the coalition, which has spoken very clearly on the need for a majority of vulnerable and disabled individuals as part of the commission. The Alzheimer's association, as we mentioned yesterday, has said that it is comfortable with appointment to an advisory committee, and I think clearly, having heard various submissions, the majority control has to be with vulnerable people.

**Mr Jim Wilson:** If I may say, the majority control is with vulnerable people, so that objection is not valid. Are there any other objections that may be valid?

**Mr Wessinger:** I'd like to go back. This act sets out a procedure for nomination and appointment in section 13. I'll reiterate what I said yesterday but perhaps not as clearly. Each of the organizations named in section 15 has a right to nominate a member of the commission, and one of those, paragraph 6, which is, "organizations representing persons with a neurological disability, illness or infirmity such as autism, Alzheimer's syndrome or traumatic head injury," can nominate an individual to the commission. It's clear that that person would likely be a family member. It would be clear, so you'd have at least one family member under that section, and I think the amendments detract from this whole nomination process through the appointment of the advisory committee. It would take away from the whole principle of the act, so that would be my objection to the amendments.

**Mrs Sullivan:** In his comments, Mr Wessinger has indicated that he believes that including family members on the commission would take away from the whole principle of the act and that family members would have a guarantee of a place through the nomination process. In fact that's incorrect.

He uses Alzheimer's patients as an example. An Alzheimer patient can be in various stages of that illness. The person who is most vulnerable as an Alzheimer's patient could not be included on the commission without the involvement of an advocate, and the organization which is doing the work in terms of support and attempting to assist patients in the early and latter stages of the illness with coming to terms with new living styles and new rights requirements is not going to be guaranteed a spot. There is no guarantee.

The government members seem to assume that because people may be nominated they will automatically be included, no matter what category they're covered in. These organizations may also, on the other hand, not name someone, not recommend someone who is a family member or a friend or who's been involved in care giving. They may decide not to put those recommendations forward, and the minister has no alternative other than to appoint people whose names are put forward by those organizations. The only constraint on that relates to geographical and cultural sensitivities.

There is absolutely no guarantee—in fact, it is more than conceivable that not only the majority but 100% of the commission will be made up of people who are disabled and that there will be no people who are family or friends of vulnerable people.

1210

**Mr Sterling:** I don't know how long we can go on with this particular argument, and I think we should vote fairly soon. It's just that you set up a committee to nominate these people, and you then have the people either appointed or not appointed by the minister. It seems to me that when you're setting up a fairly obtuse appointment system, it would be most prudent for members of the



Legislature to dictate their intention as to what the makeup of this commission is to be.

If in fact the government's intention is that it wants not a majority but all members of the commission falling within the definition of subsection 6(1), as set out for the majority, then I think you should say that to the advisory committee which is going out and looking for these people; you should be clear about whether it's a quarter you want or 30% or a third or whatever. Here we are sitting in the Legislature, and we're going to create this autonomous, or fairly autonomous, board or commission. Surely we as legislators have the obligation to say to all these people who are going to be involved in appointing these commission members what our intention really is, and I don't know what it is. I don't know whether you want seven members who fall within this definition and five that don't, or whether it's 11 and one or 12 and zero.

The advisory committee is going to be sitting around saying: "What did they want us to do? Did they want a third of the board or do they want 25% of the board represented outside of this group, or did they want all of them within this group?" I just think that when you set up a process like this, the advisory committee which is going to be putting forward these nominations to the minister should know what the intention of the government is.

**Mr Malkowski:** To respond to Mr Sterling's point and his concerns, the basic issue we're dealing with here is empowerment and giving that power to the disabled community and organizations to appoint whom they wish to represent them on the commission. They will then choose the people they want to represent them, and the minister will certainly consider what gaps are seen on the commission and can consider that at the time of appointment.

**Mr Sterling:** I have never heard such bunk in my life. Nobody in this room is denying that the commission should be controlled by this particular group, but if there's going to be so much airy-fairy fooling around in between about who is nominated to sit on the advisory committee, who will sit on the—

**Mr Malkowski:** On a point of order, Mr Chair: I wasn't finished my comments. My last comment after saying that the minister would consider any gaps during appointment was that we should then call the question. I think the microphone may have cut the interpreter off.

**The Chair:** That's not a point of order.

**Mr Malkowski:** On a point of privilege, Mr Chair: At the end of the comment I was making, the microphone was cut off. I had not finished my comment, which was to call the question. The next microphone came on beforehand. There is a bit of lag time before the interpreter is finished.

**The Chair:** I agree there is a bit of lag time, Mr Malkowski, but I had the perception that you were done, and there was nobody else speaking. Mr Sterling.

**Mr Sterling:** I'm not going to be much longer anyway. I really think you're making a mistake on this in terms of not guaranteeing those other people some kind of representation on the commission.

**Mrs Sullivan:** I am really puzzled at the way the government is digging in its heels on this issue.

**Mr Malkowski:** On a point of privilege, Mr Chair: I feel offended by this. I had not finished speaking, and I had called the question.

**The Chair:** Mr Malkowski, I've already ruled on that. I thought you were done and I did proceed to the next person. I will put you back on the list of speakers, if you'd care—

**Mrs Sullivan:** Mr Chairman, perhaps it would be useful to advise Mr Malkowski that he can't call the question, and therefore that suggestion is out of order.

**The Chair:** He can call the question when he has the floor again.

**Mr Jim Wilson:** Under the rules, he can't comment and then call the question. He has to call the question as the first thing he does when he gets the floor.

**The Chair:** Agreed. Mrs Sullivan.

**Mrs Sullivan:** I started by saying I am very puzzled at the government's intransigence on this issue. It seems that even government members are kind of uneasy and trying to rationalize what is clearly—what do you call it? some kind of boots—jackboot thinking.

**Mr Sterling:** Don't look at me.

**Mr Jim Wilson:** Don't look at us. Mike's got a pair.

**Mrs Sullivan:** I want to ask very seriously if in fact the reason for the government's intransigence in this area is whether there are specific organizations, such as, by example, the Ontario Friends of Schizophrenics, that the government does not want to be involved in the commission or in its activities in any way. I would like that answer.

**The Chair:** Mr Malkowski.

**Mr Malkowski:** I'd like to call the question so we can maybe move ahead with the vote.

**The Chair:** One piece of clarification, first, from the clerk.

**Clerk of the Committee:** I just want to clarify that if the question is put, you're putting the question on this section that was amended, and all subsequent amendments to the section now fall. I just want to clarify that that's what we're doing right now.

**Mr Sterling:** What is that?

**Clerk of the Committee:** When you put the question, you put the question on the section, with any amendments that have been passed to this point. So we're now actually voting on section 6, with the one government amendment that has been carried. Any further amendments to this section fall.

**Mrs Sullivan:** Mr Chairman, we have concurred in a process where no full sections will be dealt with until the end of the bill, that every section will remain open until the conclusion of the debate so that all the amendments, with all of their interrelating factors, can be placed at the same time. We are not dealing with any section in full now, and if that is the intention of the parliamentary assistant in putting his demand to call the question, then I want to tell you, I'm going to call for a 20-minute vote and I will



continue to break all the rules and we will have a 20-minute break before every single vote of this committee. This is clearly out of all sense of agreement of this committee.

**The Chair:** I would agree with you. We have laid down the ground rules at the very beginning; I made a statement. So I will rule this motion out of order. Further comments?

**Mr Winner:** Let's move on.

**The Chair:** Seeing no further comments on the PC motion, all those in favour?

**Mr Sterling:** Could we have a recorded vote?

The committee divided on Mr Sterling's motion, which was negatived on the following vote:

**Ayes—5**

Brown, Eddy, Sterling, Sullivan, Wilson (Simcoe West).

**Nays—6**

Carter, Malkowski, Morrow, Owens, Wessinger, Winner.

**Mr Mark Morrow (Wentworth East):** Can we now move to recess until 2 o'clock this afternoon?

**The Chair:** All those in favour of recessing until 2 o'clock this afternoon? Opposed? Carried. This committee stands recessed until 2 pm this afternoon.

The committee recessed at 1220.

## AFTERNOON SITTING

The committee resumed at 1408.

**The Chair:** I call this meeting back to order. We'll see if we can't proceed as smoothly as we did this morning, with the indulgence of the committee.

**Mr Brown:** We're with you, Mike.

**The Chair:** We're now on the Liberal motion on subsections 6(1), (1.1) and (1.2). Comments?

**Mr Malkowski:** I would like to ask for clarification. We're discussing the Liberal motion currently?

**The Chair:** The Liberal motion, alternate 1.

**Mr Malkowski:** I would like to make a comment on that motion. We would be unable to support this motion, as we are not prepared to give up the principle of empowerment and giving seats on the Advocacy Commission for families and care givers.

**Mrs Sullivan:** I don't want to go around the mulberry bush again on this, but enhancing empowerment is frequently done with the assistance of family and friends. That's what this amendment is designed to encourage and in fact require.

**The Chair:** Further comments? Seeing no further comments—

**Mr Owens:** Are you calling the vote at this point? I'd like to ask for a—

**The Chair:** Just as soon as comments and questions are done.

**Mr Owens:** Anybody have a comment?

**The Chair:** I thought you were.

**Mr Owens:** I decided to assume the chair.

**The Chair:** Seeing no further comments or questions we'll proceed to the question. All those—Mr Owens?

**Mr Owens:** I'd like to ask for a 10-minute recess, Mr Chair.

**The Chair:** A 10-minute recess? Committee will stand—

**Mrs Sullivan:** Ten or 20? Hello?

**Mr Owens:** Twenty.

**The Chair:** Twenty?

**Mr Jim Wilson:** Could we have an explanation?

**Mr Winner:** We have important things to discuss.

**Mr Jim Wilson:** You just had two hours.

**The Chair:** This committee will stand recessed until—

**Mrs Sullivan:** Could we just stand this down?

**Mr Sterling:** Can we just stand it down until they have a number here?

**Mr Owens:** That's fine. We quite agree to stand it down.

**The Chair:** Could I have unanimous consent to stand this down? Agreed.

**Mrs Sullivan:** Does this mean that there's some weakening here? Some enlightenment?

In that case I assume that my alternate 2 motion, subsection 6(1), should also be stood down.

**The Chair:** Yes.

**Mrs Sullivan:** And alternate 2, 6(1.1)?

**The Chair:** Yes.

Section 7:

**The Chair:** Now we'll proceed to, on the government reprint, clauses 7(1)(b) to (d), and we'll proceed to the Liberal motion on subclause 7(1)(b)(ii).

**Mrs Sullivan:** I spoke to this yesterday. This is comparable to the revision to subclause 7(1)(b)(ii) and I don't think we need any further discussion of it. We've had an indication that both the third party and the government support this amendment.

**Mr Malkowski:** Can we call a 10-minute recess?

**The Chair:** The vote hasn't been called, so we can't call a recess until we're ready to call the vote.

**Mr Malkowski:** Okay.

**The Chair:** Unless you want a different recess.

**Mr Malkowski:** No, then I'll comment on 7(1), on the Liberal motion.

We won't be supporting the motion because we feel that—

**The Chair:** This is the Liberal motion, subclause 7(1)(b)(ii).

**Mr Malkowski:** Oh, I apologize for that. I was on the wrong motion. Sorry, we will be voting in support of your motion because it does in fact conform with subsections 17(1), 18(1), and 24(2), (3) and (4).

**The Chair:** Further comments? Seeing no further comments, all those in favour of the Liberal motion, subclause 7(1)(b)(ii)? Opposed?

Motion agreed to.

**The Chair:** Next on the Liberal motion, clause 7(1)(d).

**Mrs Sullivan:** Once again, I spoke to this yesterday. Just as a reminder that the function of rights advice under the new Consent to Treatment Act is now separated from the rights advice and other advocacy services required under the other acts and there are different regulations associated with that. Therefore, we felt it important to separate the rights advice required by the CTA from the other requirements. We discussed this yesterday and I think there was to have been an interministerial discussion relating to this matter.

**Mr Owens:** My understanding is that there was going to be some presentation here today—is that not correct?—with respect to that issue from, whether it was Citizenship or Health. Were we not going to have that opinion heard today?

**Mrs Sullivan:** No, they were just going to have a chat.

**Mr Sterling:** As I understand it, the only requirement under the four acts that are listed here—I'm not even sure



under the Mental Health Act myself. But under the Consent to Treatment Act, Bill 109, and Bill 108, there's no requirement of advocacy services under those two acts. Am I right or wrong on that? There's rights advice required under Bill 109. Mr Fram, is there any requirement for advocacy services under Bill 108?

**Mr Winninger:** Mr Fram confirms that, yes.

**Mr Sterling:** There is? Okay.

**Ms Carter:** I think that leads on to why we would decline this motion, because it could lead to future problems because it wouldn't permit advocacy services other than rights advice to be provided under Bill 109.

**Mrs Sullivan:** There's no provision for advocacy services under Bill 109; there's provision for rights advice as a requirement of that bill. Under the other bills there are both rights advice and advocacy services, and that is why this provision is written that way: to provide for the rights advice in Bill 109 and to provide for the rights advice and other advocacy services which are required under the amendment bill, Bill 110, the Mental Health Act and the SDA. I think Mr Fram will concur that this is in fact appropriate.

**Mr Malkowski:** We wouldn't be able to support the motion, because we don't see that there would be any benefit derived from the amendment. In fact, we feel there is a possibility that there would be a possible future loss, due to the fact that it wouldn't permit advocacy service other than rights advice under consent to treatment.

**Mrs Sullivan:** I think the statement that has just been made by the parliamentary assistant to the Minister of Citizenship reflecting on the Consent to Treatment Act deserves a policy response from the parliamentary assistant to the Minister of Health. Bill 109 has no provision for advocacy services other than rights advice. Rights advice is specified as the nature of information that is conveyed to people who are determined to be incapable. Rights advice is the only service offered and included under Bill 109. Advocacy services would have to be obtained under the provisions of Bills 74 and 108, and it would be quite possible to do that. But under Bill 109, it's rights advice.

1420

**Mr Wessinger:** I think it's appropriate that this one be stood down, as I would be interested in reviewing it with Citizenship. I'd ask that it be stood down.

**The Chair:** Do we have unanimous consent to have this one stood down? Agreed.

Next, Liberal motion 7(1)(h).

**Mrs Sullivan:** I spoke to this yesterday as well. This amendment would mean that the entire section would read, "acknowledge, encourage and enhance individual, family and community support for the security, rights, needs and wellbeing of vulnerable persons." We feel this is an important duty of the commission, and we hope the government will see fit to accept this particular section.

**Mr Malkowski:** We will not be able to support this amendment because it actually can be detrimental to the individual's right to choice and empowerment.

**Mrs Sullivan:** How would that be? I'd like some explanation of that response. It sounds fairly flip to me.

**Mr Malkowski:** What's important is that we're talking about the freedom of that individual vulnerable person to choice and empowering that individual.

**Mrs Sullivan:** This kind of explanation is simply inadequate. We are asking, as one of the commission's duties, that the commission be required to "acknowledge, encourage and enhance individual, family and community support for the security, rights, needs and wellbeing of vulnerable persons." How does that interfere with freedom of choice? If my additions mean there is interference with freedom of choice, then the government's first position in clause (h) also negates freedom of choice and the entire clause should be removed. Where are they coming from?

**Mr Jim Wilson:** Hold on to your seats, but I'm going to support the government on this motion. To be fair to Mr Malkowski, his first explanation this morning, when similar wording came up in another clause—and it was a compelling argument—was that someone may trample on the rights of an individual using the excuse that he's tending to that person's needs. To be fair to Mr Malkowski, I think that's what he probably means to say at this time, and I agree with him. Mr Sterling and I split on it this morning, and Norm may even be on side this afternoon; I'm not sure.

**The Chair:** Further comments? Seeing no further comments, all those in favour of the Liberal motion on 7(1)(h)? Opposed? We all have to vote, Mr Sterling.

Motion negated.

**The Chair:** Next, we'll move to government reprint 7(1)(k) and 7(5), in which case we'll go to the Liberal motion on 7(1)(k).

**Mrs Sullivan:** As I indicated yesterday, this amendment should be considered in association with my amendments that are being put forward on section 36. We could either deal with both of those now or we could deal with them both in the order of 36. I don't know how you want to proceed.

**The Chair:** Would you like to have this stood down until we go to 36?

**Mrs Sullivan:** It's fine with me.

**The Chair:** Do we have consent for that? Agreed? Okay.

Also, 7(1)(k) will be stood down? Alternate 2?

**Mrs Sullivan:** No. That one does not have to be stood down, the alternate 2.

**The Chair:** Okay. We'll go to Liberal motion on 7(1)(k), alternate 2.

**Mrs Sullivan:** This motion is to once again acknowledge that there is a separation between the role of advocates, whose duties may include the provision of rights advice, and those individuals who are only providing rights advice, as required under Bill 109. We wanted to make that separation to ensure that there was an understanding that there were two people for whom qualifications, standards



and codes of conduct, by example, would be required and, later, whose training requirements may differ.

**Mr Sterling:** I have a question. We heard conflicting testimony here. Is the Advocacy Commission going to hire people who are called "rights advisers"? On the one hand I thought I heard people who were involved with the advocacy movement say that was going to be the case, and on the other hand I think I heard the government say yesterday that was not the case. Can I have an answer to that question?

**Mr Malkowski:** I think the issue is that this section is not actually defining rights advice at all in this act. In fact, we're talking instead about rights advice under advocacy service as incorporated in advocacy service. If we were to incorporate that, we would have to have an exhaustive re-examination of the act and to determine all the situations in which rights advice should be mentioned, and in fact rights advice is actually a function. We're not dealing with the person himself, the rights adviser.

**Mr Sterling:** All the people who will be giving rights advice, hired by the commission, will be advocates. Is that a correct statement?

**Mr Wessenger:** Yes. I'd just like to point out that section 2 of the act defines an advocate as a person who's authorized under subsection 7(4) to provide advocacy services on behalf of the commission. Then if you look under the definition of providing advocacy services, clause 7(1)(d) says "provide rights advice." So anyone designated to provide rights advice under this act will be deemed an advocate under this act. Consequently, they're covered.

1430

**Mrs Sullivan:** I think we're really going back to the fundamental conflict between Bills 108 and 109 and Bill 74. If you look at the definition of rights adviser under 109, there is an area which says that in the prescribed circumstances a person who is a member of a prescribed category is a rights adviser; that is, in addition to a person who is authorized under the Advocacy Act, 1992, to provide advocacy services on behalf of the commission.

It's apparent that Bill 109 envisages rights advisers who are not only those who are providing advocacy services under Bill 74. How are they trained? What is their code of conduct? What standards do they have to follow? Does that come from the commission? Does that come from anywhere? Because there's no other place that will come.

The point is, who is responsible for this new group of rights advisers who bear no relationship to the commission? Who is responsible for their training, their code of ethics, their standards, their accountability? We know how they can be appointed, but there are all sorts of other things we don't know in terms of minimum qualifications and other things.

We asked the parliamentary assistant to the Minister of Health yesterday to inform the committee on basically the policy directions. Where are those people going to be coming from? Are they going to be employees? Could they be employees, by example, of hospitals? If they are, to whom are they accountable?

I don't think we can deal with this section and that whole issue unless we refer to Bill 109 and the requirements for specific rights advisers, which are included under their regulations.

**Ms Carter:** It's my understanding that all rights advisers would come under the Advocacy Commission and therefore would be subject to all the same—

**Mrs Sullivan:** Not unless you include them.

**Ms Carter:** —requirements that an advocate would have to fulfil.

But having said that, there could be different categories of advocate. Some people might be rights advisers and might be specially accredited to do rights advice rather than to be a full advocate, but they would nevertheless come under all the provisions of the commission as far as codes of conduct and so on were concerned.

**Mr Wessenger:** First of all, with respect to this particular amendment, there is the problem in the fact that this act does not define rights advisers, and if you were to incorporate this motion, it would involve an exhaustive re-examination of the whole act to determine all other situations where rights advisers should be mentioned.

Second, I think the discussion with respect to role of rights advisers on the Consent to Treatment Act properly belongs under that act and not under this.

Third, I think it might be helpful to all members if counsel were to give the interpretation of this act with respect to the question of the accountability of rights advisers under this act. That might be of some assistance to members of the committee.

**Ms Perlis:** Succinctly, as Ms Carter has stated, that rights advice is not defined in this act. If it is required to be provided within this act, it will be provided as an advocacy service and therefore will fall under all of the controls, strictures and requirements that advocates are to conform to as determined by the commission.

**Mr Winninger:** I just wanted to state for the record, as Ms Sullivan referred to our bill, Bill 108, that our bill is quite clear in defining advocate as being authorized under the Advocacy Act. We don't mention rights advisers. The authority of the advocates who appear in Bill 108 is pursuant to Bill 74. I don't believe there's any problem there.

**Mrs Sullivan:** There is a problem with 109.

**Mr Winninger:** Right, but you mentioned 108 and I just wanted to say what I said for the record.

**The Chair:** Further discussion? Seeing no further discussion, all those in favour of the Liberal motion on clause 7(1)(k), alternate 2? Opposed?

Motion negatived.

**The Chair:** Now we'll go to the Liberal motion on subclause 7(1)(k.1)(i.1).

**Mrs Sullivan:** There are three or four amendments that relate to this entire issue that we have been discussing, and this amendment is put forward to assist in once again clarifying the interaction and the government's policy intent with respect to rights advisers. The counsel for the Minister of Citizenship has indicated that if advocacy services are required under Bill 74, they will be provided by Bill 74. If



rights advice is required in situations under Bill 74, they will be provided by Bill 74.

We have a problem in that we have rights advice required by Bill 109 that is separate, and apparently by inference, from what the counsel has indicated, those people will not be subject to the authorization and the standards and training and so on of Bill 74. Yesterday I asked for an indication of the government's policy intent with respect to rights advisers, and I think that, before we go any further, we must have that understanding with respect to Bill 109.

If the government's policy intent is that on occasion a nurse in a physician's office could be authorized to provide rights advice, if the government's intent is that certain employees in a hospital could be authorized from time to time to provide rights advice, then perhaps we should make that very clear in Bill 109 and separate the rights adviser role completely into 109 that's required for 109.

If that is not the intent and if there's an intent to roll back the 109 rights adviser into the Advocacy Commission and under the authorization and guidelines and standards that are put forward by the Advocacy Commission, then I have a series of amendments that will in fact allow that to occur. But what we need and want is a coming clean on where the government is going in terms of the independence of employment of rights advisers under Bill 109.

**Mr Malkowski:** We won't be able to support the motion because it's completely contrary to the philosophy of the act that advocacy services should not be provided by care givers. However, there is nothing that would preclude the commission from contracting with an individual who is not a care giver, if it chooses to do so.

**Mrs Sullivan:** Does the parliamentary assistant to the Minister of Health concur? What is the policy intent with respect to 109?

**Mr Wessinger:** I would concur that the intent of this legislation is to have rights advisers not be employed by a faculty of a controlled-access residence.

**Mrs Sullivan:** So under no circumstances, you are saying, will rights advisers—

**Mr Wessinger:** That's the intent of this package of legislation as I would interpret it.

1440

**Mrs Sullivan:** Under Bill 109 a rights adviser will never be employed in the designated category in positions, for example, of being a nurse in a physician's office, being a staff member of a hospital, being a care giver in a nursing home. Those people will never, ever, in any circumstances under Bill 109 be considered or allowed to be a rights adviser. That's the information that we want.

**Mr Wessinger:** That is the present intention, yes.

**Mr Jim Wilson:** Just getting back to the motion at hand here, I would like to have a clarification from the mover of the motion of exactly what the intent is. As I read this, Mrs Sullivan, you want to replace 7(1)(k.1), replace all of what appears in the reprint, with your (i.1). Could you explain the reasoning behind that?

**Mrs Sullivan:** Just adding a clause.

**Mr Jim Wilson:** You're adding a clause?

**Mrs Sullivan:** Adding subclause (i.1).

**Mr Jim Wilson:** I see. You're adding (i.1) type thing. I still don't get the gist of it, though, Mr Chairman, if someone could provide an explanation.

**Mr Sterling:** I oppose this amendment because basically I would hope that the arrangement under Bill 109 could be a little less formal than having the Advocacy Commission involved in every rights advice situation. Therefore, I would not support this amendment.

**Mrs Sullivan:** Given the final policy confirmation from the parliamentary assistant to the Minister of Health, I will withdraw this amendment.

**The Chair:** Okay, that amendment's withdrawn. Next, we'll go to the Liberal motion, alternate 1, on 7(1)(k.2).

**Mrs Sullivan:** Once again, this amendment would have to be considered with proposed amendments to section 15.0.1, so I'd like to stand this down so that it could be considered with those and with the Conservative proposal for amendment at the same time.

**The Chair:** Do we have agreement to stand this one down? Agreed.

**Mr Wessinger:** I notice in the reprint there's probably a typographical error or some type of error, and I don't know whether it needs an amendment or not. It's on (k.2). The reprint says, "establish, subject to the approval of the Minister of Citizenship," and the "of Citizenship" really should not be in there. I don't know whether than can be removed as a typographical error or—

**Mr Winninger:** We stood down that section earlier so they could bring them all into line.

**Mr Wessinger:** I just wanted to bring to the attention that it's an error of the nature of a—

**Mrs Sullivan:** Mr Chairman, I have an amendment that does exactly that.

**Mr Winninger:** I thought we just stood down the issue so that the ministry could bring all the sections into line rather than doing it piecemeal.

**Mrs Sullivan:** We didn't know why the request was made to stand it down, but I have included in my amendments—

**The Chair:** That's on Liberal motion, alternate 2, on 7(1)(k.2)?

**Mrs Sullivan:** Yes.

**The Chair:** It is slightly different. We'll proceed with 7(1)(k.2), Liberal motion, alternate 2.

**Mr Jim Wilson:** Are you sure we didn't cover that already, Mr Chairman?

**The Chair:** Alternate 2? We stood down alternate 1, now we're on alternate 2. Any comments? Mr Owens? No comments. Mr Malkowski.

**Mr Malkowski:** I ask that we stand this down.

**The Chair:** Do we have unanimous agreement to stand this one down? Agreed. Liberal motion, alternate 2, clause 7(1)(k.2) has been stood down.

We'll move to Liberal motion, clause 7(1)(k.3). Comments?



**Mrs Sullivan:** The intent of this motion is simply to add rights advisers in when they're required for training programs.

**Mr Sterling:** I think it best that we not mix rights advisers in with this legislation, period, and the term "rights advisers." I think as far as I understand the legislation now, these are advocates. Advocates are going to be advocates and there isn't going to be anything less than an advocate and therefore "rights advisers" is a more appropriate term under Bill 109. Therefore, I would oppose this particular amendment.

**Mrs Sullivan:** I'll withdraw this motion and the next one.

**The Chair:** Liberal motion, clause 7(1)(l) is also withdrawn. We'll now proceed to Liberal motion, subsection 7(2).

**Mrs Sullivan:** This amendment deals with an issue which was before the committee on several occasions and the questions have been raised on several occasions. While we all understand the necessity and in fact the importance of advocacy being independent from the provider of services, my sense is that the commission would be unduly limited if it could not, from time to time, involve organizations which do provide other services, whether they're in housing, whether they're vocational, whether they're legal; they might be fund-raising services. In terms of its freedom and ability to involve others who have expertise in certain areas, who've had experience in certain areas, in regions perhaps where there is limited ability for people to form organizations on their own, because there perhaps might not be 20 people who could form an organization that would be recognized by the commission as able to provide advocacy services, there may as well, because of the limitations here, be a duplication of service.

1450

It seems to me that with the commission's power in determining its own approach and rules with respect to the provision of advocacy services, it can say that advocacy services cannot be provided, by example, within a certain institution by an employee of that institution. However, there may well be occasions when people from that institution would be very useful in providing advocacy services in another context or in another area.

The other concern of course is the geographical limitations, to ensure that services can be available even in the remotest parts of the province, and that's why we've put this amendment forward. I have no apprehensions that the government will support it, but we feel that the commission is going to be unduly limited by not supporting it.

**Mr Sterling:** I want to support this amendment, particularly for small communities in the province who don't have the luxury of having the kind of agency to provide vulnerable people with advocacy services, because there just aren't large enough numbers to have a multiplicity of kinds of agencies which could provide that kind of service. I don't know why we would want to hamstring the commission with such a restrictive clause.

For instance, it seems to be that a non-profit community agency, which would be providing one kind of service,

may be very capable of advocating on behalf of a vulnerable person with regard to another completely unrelated kind of service. I just don't know why the government would want to restrict the Advocacy Commission that way.

It seems to me that the Advocacy Commission would always look for the kind of situation where there could be no conflict at all, but that's operating in the ideal world. If you go out to some of the smaller communities where you have 400 or 500 people living a long way from other areas, the choice then may be no advocacy services, because we have placed this restriction on them. I'm just speaking on that end of it.

**Mr Wessinger:** I'm going to oppose this motion because of what I understand of the principles behind this Advocacy Act, and that is to create a form of advocacy which does not involve any conflict of interest situation, which is to be a form of secondary advocacy after primary advocacy has failed, and also to preserve many of the existing advocacy services that do exist; it's not really to supplant or replace them.

I think what would happen with this motion would be bringing practically all advocacy services—or it could be interpreted that way—under the commission. I look at this act as a secondary form of advocacy only after the primary advocacy has failed or where there's a particular gap that may have to be filled. I would hope that the advocacy services that are now being done by many service providers will continue to be done and this is just an addition, a non-conflict of interest position on top of the whole provision of advocacy services in our society.

That's certainly the principle of it, and I think that principle is very important: to preserve that independence, that secondary role, to ensure that all the existing advocacy services we have provided in our community continue; and we have this on top as a protection, as an addition, as a gap filler. That's why I would oppose the motion.

**Mr Malkowski:** In response to Mr Sterling's concerns as well as Ms Sullivan's, specifically in relation to the northern areas and advocacy service, what we have to remember is that we have heard specifically from consumers who very emphatically said they do not want to have advocacy provided by care givers, that they want to see that separation and that advocacy be a more independent service. In the northern areas, advocacy can be done possibly through church communities where there's not a conflict of interest between care givers, for example. So there are possibilities that can be considered in the northern regions.

**Mrs Sullivan:** That's precisely the point. The very example Mr Malkowski has used is an example of the situation that is excluded if this provision remains in. The church group, because there are other services being provided to vulnerable people, will be unable to perform those functions to many of the people in the area. That is precisely the situation that is problematical.

**Mr Malkowski:** In response to that, the church does not receive government funding; there is not that conflict of interest. They are very much an independent body. There would not be a conflict of interest financially under those terms whatsoever.



**Mrs Sullivan:** I don't understand what that has to do with the issue. There's no provision in this bill that says anything about government money. This talks about non-profit community agencies, and government moneys have nothing to do with the issue.

**Mr Sterling:** I just don't understand why you mistrust the commission to make the right choice in picking their agency.

**Mrs Sullivan:** That's right.

**Mr Jim Wilson:** And what's best for the local areas.

**Mr Sterling:** And what's best for the local area. They're going to come to a reasonable conclusion. I trust the Advocacy Commission to make the right decision. They're not going to hire some agency which is going to come in direct conflict with these people all the time. They're going to make the best choice. I don't understand why you want to tie their hands.

**Mr Jim Wilson:** I want to know what the term "non-profit" means, because in my riding, when we hear that term we grab on to our wallets and we duck. For instance, I've got day care operators making far more money now under the non-profit scheme than they ever did as a private operator, so I want to know what the term means.

**Ms Carter:** I think the problem here is that we're confusing what you might call informal advocacy—which is always going to happen: people are always going to give advice; a nurse can give advice, a clergyman can give advice—with the Advocacy Commission as such. People who are employed by that commission are accredited; other people can give advice as long as they don't claim that accreditation. But anybody who does work under the Advocacy Commission must be seen to be free of any kind of conflict of interest.

I think this is absolutely basic to the philosophy of what we're trying to do, and I believe the Advocacy Coalition itself, which consists of groups who are concerned about this kind of issue, is very strong on this point that the avoidance of conflict of interest is absolutely of prime importance and that we can't give way on that.

1500

**Mr Winner:** Separation of church and state.

**Ms Carter:** Absolutely.

**Mr Jim Wilson:** I won't get into that, but I do want an answer to my question, because I hear this in the Legislature and I heard it on the campaign trail and we'll hear it again next time around, all this non-profit and not-for-profit stuff. Perhaps I could ask legal counsel. Is there a definition? Do you register your group? What do you do? Does it pertain to the Income Tax Act?

**Ms Perlis:** I believe the answer to that question would be that the agency would be incorporated under the Corporations Act as a nonprofit corporation.

**Mr Jim Wilson:** Under the Corporations Act. Are there any examples? Why the preference for non-profit here? Are there certain groups that will be excluded? Does the parliamentary assistant have any comment on that?

**The Chair:** Any response? No?

**Ms Perlis:** There is a requirement that it be a corporation in order to flow funds from the commission to the corporation.

**Mr Jim Wilson:** I appreciate that.

**Mrs Sullivan:** I don't want to stay too long with this, but I want people to understand that in limiting the commission, as it has with this section—when you look at the duties the commission will be authorizing non-profit agencies to do, it includes: to promote respect for vulnerable persons; to provide advocacy services both to people who are capable and incapable of instructing the advocate; to participate in advocacy services in systemic change, to provide rights advice and so on, to ensure that the community development programs are put into place.

With this amendment, none of those activities can be authorized by the commission, can be requested or a contract given by the commission to organizations such as heart and stroke, cancer, diabetes. You'll recall that we had the diabetes association before us. One of the things they do is systemic advocacy, with respect particularly to assistive devices changes; they talked particularly about drivers' licensing issues. If there are broad-based issues such as that, that organization could not be authorized by the commission to assist in providing, in an authorized way, systemic advocacy. It would be just left out; it will not count.

If you want to be inclusive, then you accept my amendment; if you want to be exclusive, you don't.

**Mr Malkowski:** The legislation does not stop non-profit organizations from offering that type of service. In no way will it stop those services from being provided. It is not going to stop the diabetic foundation from continuing to provide systemic advocacy.

**Mrs Sullivan:** The commission won't have advantage of it.

**Mr Sterling:** We continue to have voluntary agencies who are continually looking at ways to get out of providing hard services. They want to get out of doing that now, and many of them would rather do the advocacy than do the hard, down-on-the-ground work of providing services to cancer patients, and all of the very important work that governments, I don't think, can do as well as they can.

What we're doing here, by excluding them from any kind of government funding with regard to advocacy services, is saying: "Well, you've got a choice. You can get some money from the government if you get out of providing hard services, but you can't get any money if you provide hard services." It's another encouragement for them to dump over on to the taxpayer another hard-core service which is being provided somehow out there by charitable organizations.

I just think it's wrongheaded for the two reasons that I point out. Why not leave the decision up to the Advocacy Commission to make the priority on how they're spending their money and how they're going to provide advocacy services?

**The Chair:** Further discussion? Seeing no further discussion, all those in favour of the Liberal motion on subsection 7(2)? Opposed?

Motion negated.

**The Chair:** Next we go to the Liberal motion on subsection 7(2.1).

**Mrs Sullivan:** I withdraw that motion, Mr Chair.

**The Chair:** Withdrawn.

**Mrs Sullivan:** And the next motion.

**The Chair:** And the next one.

**Mr Malkowski:** You've withdrawn 7(2.1). What was the other motion that was withdrawn?

**The Chair:** Subsection 7(4.1).

We'll go to the Liberal motion on clauses 7(5)(c) and (d).

**Mrs Sullivan:** In looking at this, I thought that once again—and this is a very small point; we don't have to stay for an awful long time on it—in terms of the public information and education requirements or responsibilities of the commission, it seemed to me that the best approach would be to eliminate, first of all, non-professional persons who provide care to vulnerable persons.

I assume that you're trying to capture people who are in residential services employment or in vocational services employment. Some of those people call themselves professionals, and we haven't defined "professionals," or even if they're non-professionals as a regulated profession.

As well, I think we're missing in this case, for example, people who are lawyers, who may also be providing services, people who are providing housing. Housing is not included here. Certainly those areas are areas that we know require education programs in terms of learning how to deal with and raising awareness of issues facing disabled and vulnerable people.

It just seemed to me a neater way of ensuring that everybody who should know about the issues and the problems. The commission should be conducting communications programs, as it can afford to and within its target funding to do that.

**Mr Malkowski:** I think Mrs Sullivan's points are very reasonable and well taken and we will be able to accept this motion. We feel it certainly doesn't change the substance of the section, but in fact it simplifies the language. We are happy to support that.

**The Chair:** Further comments? Seeing none, all those in favour of the Liberal motion on clauses 7(5)(c) and 7(5)(d)? Opposed?

Motion agreed to.

**The Chair:** With the indulgence of the committee, we'll now have a 10-minute recess. We'll meet at 3:20.

The committee recessed at 1511.

1541

Section 8:

**The Chair:** I call this committee back to order. In the reprinted version, government amendment 8(3) is just a deletion, so that'll be reflected when we vote on the whole section later on. We'll now go to the government motion on subsection 8(1).

**Mrs Sullivan:** Yesterday, when we were going through the initial process here, the government had indicated that it wanted to have interministerial consultation on

certain aspects of the bill, of the amendments that were put forward. Today, when those amendments were reput, the government indicated it again wanted consultation. It would be useful for us to know if the government has had that consultation and when it's going to get back to us with information respecting those subsections which have been stood down.

Have they taken their break and consulted, or is this something that's going to occur at some time in the Never Never Land ahead? If it is something that is not going to be before us today, we in fact can't proceed in the way we had agreed to proceed in terms of completing Bill 74 today.

**Mr Malkowski:** We have had an opportunity to discuss the issue; however, there is still ongoing debate on that issue. As far as interministerial issues are concerned, there are certain issues that will impact all three bills, so I feel we should continue with 74 and deal with those segments as best we can.

**Mrs Sullivan:** Is it the government's intention to come back with information to us that it had indicated yesterday it wanted to discuss so that we can in fact complete Bill 74 today fully? The only reason that we stood down those sections was that we had hoped that the government was going to do what it said it intended to do, which was to discuss how it would approach the amendments.

**Mr Malkowski:** Can I ask for just a five-minute or 10-minute recess so that the government members can discuss the issue and respond?

**The Chair:** All those in favour of a 10-minute recess? All those opposed?

**Mr Morrow:** What is the recess for, Mr Chair?

**The Chair:** Mr Malkowski has asked for a 10-minute recess so that they can get back with a response to Mrs Sullivan's inquiries about whether or not there will be anything forthcoming today on an interministerial statement.

**Mr Winninger:** I would support that.

**The Chair:** All in favour of a 10-minute recess? Opposed? Carried. We will have a recess until five to four.

The committee recessed at 1546.

1602

**The Chair:** I call this meeting back to order. Are there any comments from that recess? Mr Malkowski.

**Mr Malkowski:** The government members would like to continue with those outstanding motions and then we will go back to those motions that were stood down and debate those.

**Mr Sterling:** Mr Chairman, I'm getting awfully tired. When are we going to break for dinner?

**The Chair:** The Chair is at the indulgence of the committee.

**Mr Sterling:** I say that in jest.

**The Chair:** I realize that, Mr Sterling.

We will now proceed with the government motion on section 8.1. Comments? Seeing no comments—



**Mrs Sullivan:** Mr Chairman, could we have an explanation from the government for the reason for this motion?

**The Chair:** Go ahead, counsel.

**Ms Perlis:** The motion actually reflects an oversight in the original drafting of the bill. The clauses proposed resemble delegation clauses found in most other statutes: the Pay Equity Act, the Ombudsman Act, the Human Rights Code. Without it, any decision or function required to be performed by the commission legally would be required to be performed by all of the commissioners in the absence of a legal delegation clause.

**Mr Jim Wilson:** Could you go by the latter part again of that explanation?

**Ms Perlis:** Any function in the bill required to be performed by the commission in the absence of a clause such as the one proposed would mean that it would have to be done by each and every one of them. There would be no statutory provision for delegation of a function, such as the giving of consent to an advocate to access records for systemic purposes, which the commission must consent to.

That consent would have to be given by each and every commissioner, in the absence of a clause such as this one, any place in the act where it says the commission shall consent or make a decision. It also allows administrative delegation from the commission to officers or employees of the commission.

**Mr Sterling:** Just a minute now.

**Ms Perlis:** There are two, part A and part B.

**Mr Sterling:** Yes, there are two.

**Mr Jim Wilson:** Part A is fine, part B is problematic.

**Mr Sterling:** You're basically saying the chair of the commission can delegate the right to gain access to records to some bureaucrat. Am I not correct in that interpretation by reading your amendment?

**Ms Perlis:** Essentially. It would allow the chair to delegate to officers. That's correct.

**Mr Sterling:** The explanation of the need for it is that the commission can delegate to the chairman of the commission. I'm in agreement with that, but what we're saying is he can delegate any of his duties and his powers to anybody in the commission, including the receptionist at the door. Now that's not going to happen, but notwithstanding that, there are some pretty intrusive powers that are given under the auspices of this commission.

Why do they need such a wide delegation clause? Even under the freedom of information act, I believe there are certain functions that only the commissioner or the assistant commissioner of freedom of information can do himself or herself. I can remember having the battle during that legislative hearing that we would allow some delegation, but only to very few people when you're dealing with sensitive information about personal individuals. I find this far, far too wide and very, very dangerous.

**Ms Perlis:** I wonder if I could just point out, for example, that it resembles the delegation clause in the Ombudsman Act which allows the Ombudsman, in writing, to delegate to any person holding office under him.

It also would be impossible to function administratively without this kind of delegation clause. I suppose it could be possible to rework the clause, although we feel the chair and the commission will exercise the delegation authority appropriately.

**Mr Sterling:** I guess the problem I have, particularly in the information issues, is I want the commissioner and the people in the commission to understand that when they give out that power to get information, it's something special. It's not a normal, run-of-the-mill kind of decision that's being made. Therefore I have a great deal of difficulty with the blanket delegation that you're giving to the commission to hand this off to them.

I don't know whether you can split off the particular delegations dealing with the sections relating to information. I think I have delineated those. I think 17(1), 18(1) and 24(2) are the relevant subsections, and I would agree to a restrictive clause of delegating this to the chairman of the commission or any other two commissioners or something like that.

**Ms Perlis:** Perhaps from a policy standpoint, I can clarify that the intent was discussed with legislative counsel who may want to address the actual drafting. The intent basically is the issue of policy procedures, that sort of thing, being delegated from the commission as a total to the commissioner or a subcommittee of the commission and administrative responsibilities being able to be delegated to staff. It was the advice of legislative counsel that the wording as it is, where there can be restrictions as it considers appropriate, was the appropriate way to do the wording here.

I think the general concern is not one that would seek wide-open delegation but one that would have appropriate delegation clauses that are usual in that.

**Mr Jim Wilson:** Is it possible then, with that explanation, to ask for some rewording to be brought back to the committee?

**The Chair:** We can stand it down. Is the committee agreed? Agreed.

1610

Section 9:

**The Chair:** Next is government motion on 9(1). It seems to make more sense to do the Liberal motion first on 9(1).

**Mrs Sullivan:** Mr Chairman, I withdraw that motion.

**The Chair:** Withdraw? All right. There is a PC motion on 9(1).

**Mr Sterling:** This clause restricts the liability of people who are advocates or a member of the commission. I'm concerned about the scope of the release of liability or the lack of liability on the part of people who are given what I consider significant powers.

I have moved under the amendment yesterday that an advocate or any person who works for the commission or the commission should not be exonerated from liability for neglect or default in the execution in good faith of the person's duty. I have a real problem here in that advocates, in taking on the responsibility of looking out for a vulnerable

person, should not feel the weight of responsibility associated with taking on that duty to represent them.

I guess I relate it somewhat to the role I assumed when I practised law, when I took on the duty of representing a client and felt the responsibility that I could not avoid liability just because I said I forgot to do something. Therefore, I think the whitewashing of the whole matter in terms of allowing them off the hook for neglect or default in doing what they are supposed to do is totally inappropriate for people who are put in this kind of position.

They're going to be operating on their own to a very large degree; they're going to be out there in the community; the chairman of the commission is not going to be able to know in every case, or keep his or her fingers on each and every advocate. I think they have to understand that when they walk out there they're personally responsible for how they conduct themselves and that if they forget to do something on behalf of somebody they're on the hook.

Even though they are hired by somebody else, I see that this position of advocate should not have the same kind of cloak of protection a civil servant might expect to get in terms of being a member of the civil service of Ontario, for instance, for what he or she might do under her job. I don't think we can afford to give that kind of protection to an advocate who is out there in the field, because of the nature of the job.

**Mr Malkowski:** We can't support the motion because this section, as currently drafted, is in fact standard wording insulating individuals from any personal liability.

**Mr Wessenger:** I would like to add that it seems clear that the question of liability on whether a person acts or fails to act should be the same, that is, whether they do it in good faith. That's the intention of the provision and that's what the standard provision provides, that you judge the failure to act and the act on the same basis. What Mr Sterling's motion would do would be to create a higher liability for failure to act than for doing an act.

**The Chair:** Further discussion?

**Mr Sterling:** I'm sorry to hear the parliamentary assistant not willing to go the extra step to protect vulnerable people in this province. I do believe that advocates under this system have to have the same kind of responsibility and liability as a lawyer would if he or she acted on behalf of a vulnerable person in the community. I think they should feel that responsibility when they make decisions about how they're going to conduct themselves with regard to dealing with vulnerable people. We're going to require a high degree of professional capability with regard to what these people are doing.

I'm sorry to see that all these advocates are going to be able to operate without any kind of personal responsibility. As the act is now written, there's no discipline procedure even to scold an advocate for acting in an unprofessional manner, even if it were intentional. It seems to me that this degree of protection for these particular individuals is far, far too great for the job they're doing. I'm sorry that you're not requiring that high standard from your advocates. As a consequence, when you don't put the personal

responsibility on their shoulders, you won't get the high performance from your advocates. It just will not follow.

**Mr Malkowski:** Having listened to your concerns, Mr Sterling, I would like to ask our counsel to make some comments on that.

**Ms Perlis:** I'd like to point out a few things. Firstly, the protection from personal liability is only in relation to acts done in good faith by the advocate.

Secondly, I'd like to point out that subsection 2 of that section makes the commission and the community agency vicariously liable for the acts of the advocate, and the advocate, as an employee of the commission or community agency, can have his or her authorization—and employment contract—terminated as a consequence of any wrongdoing.

Thirdly, I'd just like to point out that the protection given to advocates under this act is the same as that extended to child protection workers under the Child and Family Services Act, who are also protected for acts done in good faith; their powers of intervention, entry, access and so on with respect to vulnerable children are coextensive to those of the advocates under this act.

**The Chair:** Further discussion? Seeing no further discussion, all those in favour of the motion by the PCs on section 9(1)? Opposed?

Motion negatived.

1620

**The Chair:** We'll now go to the government motion on subsection 9(2). Comments?

**Mr Jim Wilson:** This is in the reprint?

**The Chair:** My apologies, we should go back to the motion on subsection 9(1) in the government reprint. Any comments? Seeing none—

**Mrs Sullivan:** Is that the one that's reprinted?

**The Chair:** Reprinted in the bill, the underlined part. No comments? All those in favour of the government motion? Opposed?

Motion agreed to.

**The Chair:** Now we go in the reprint to government motion on subsection 9(2). Comments? Seeing no comments, all those in favour? Opposed?

Motion agreed to.

**The Chair:** Next we go to the Liberal motion on clause 10(1)(a).

**Mr Jim Wilson:** Just following the road map, there is a deletion of subsection 8(3). Do we vote on that, or do we not vote on deletions?

**The Chair:** That's a deletion. When we vote on the section, that will be incorporated.

Section 10:

**The Chair:** Okay, the Liberal motion on clause 10(1)(a).

**Mrs Sullivan:** This motion relates to the advisory committee and changes the requirement for the composition of that committee from a majority of members being from groups of family members of vulnerable persons,



non-professional persons who provide care and health and social service practitioners who provide services to being a committee that's composed solely of persons from those groups.

**Mr Malkowski:** We won't be able to support this motion, because we feel it's important that the advisory committee does not become isolated from the perspective of vulnerable people. In fact, it's critical that their viewpoint and perspective is shared within the committee and that it's not a separate entity or a separate part of the committee.

**Mrs Sullivan:** I now recall why I put this amendment forward. It is to point out the irony that the government will not allow family members and friends and health care providers, people who are providing care and services to vulnerable people, to be a part of the commission, and yet uses the argument that other people must be part of the advisory committee, people who are themselves disabled and so on, because otherwise there could not be a communication of the needs and requirements. It is just delicious irony, and that was the real purpose of this amendment.

**Mr Jim Wilson:** Just for the record, I will not be supporting this amendment. I agree with some of the comment made by Mr Malkowski, that this would limit the function of the committee and the ability of the commission to establish other committees. It doesn't make any sense to me.

**Mr Sterling:** To be consistent with my arguments this morning in terms of saying that the commission should be able to function, make real and good decisions, in support of my motion with regard to that I cannot agree with what is put forward here, because I believe that both the advisory committee and the commission would be well served to have all of the players on them but the majority should be reversed with regard to the two bodies. I find it odd that Mr Malkowski is using the selfsame arguments that I used with regard to the commission when dealing with the committee.

**Mr Jim Wilson:** Mr Chairman, I just want to point out that I erred in my reasoning and that I read that the motion would also strike subsection 10(b). None the less, I'm still opposed to the Liberal motion.

**Mrs Sullivan:** Mr Chairman, just to conclude these remarks: In fact, in reality I don't support this motion myself. I wanted, however, to put it on the table so that there will be an understanding of what the government is doing with respect to the composition of the commission and the composition of the advisory committee.

On the commission, the government is being exclusive. On the advisory committee, the government is being inclusive. The government is using the precise arguments for maintaining the drafted composition of the advisory committee as we are using in respect to the composition of the commission itself. We do not see or understand the logic of that thinking, the practicality of that thinking and do not see anything other than an inconsistency and a stubborn insistence on an ideological approach that, in fact, is going to hinder the activities of the commission.

That's why this amendment is being put forward: to simply underline the ridiculousness of the government's position on the setup of the commission.

**The Chair:** Further discussion? Seeing no further discussion, all this in favour of the Liberal motion on clause 10(1)(a)? All those opposed?

Motion negatived.

**Mr Sterling:** On a point of order, Mr Chairman: It's quite proper parliamentary procedure to put forward a motion which you do not necessarily support.

**The Chair:** Yes, it is. Thank you very much.

Now, on the Liberal motion on paragraph 10(2)2.

**Mrs Sullivan:** Mr Chairman, I have a replacement motion for this motion to reflect the identical change which was made to an earlier section.

**The Chair:** Mrs Sullivan moves that paragraphs 2 and 3 of subsection 10(2) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"2. Persons who provide care and services to vulnerable persons."

Could we stand this down until legislative counsel could write it up?

**Mrs Sullivan:** Sure.

**The Chair:** Thank you. You are withdrawing your other motion on paragraph 10(2)2?

Interjection.

**The Chair:** Thank you. Next we go to a Liberal motion on subsections 10(3), (4) and (5).

1630

**Mrs Sullivan:** Could we have a Progressive Conservative motion taken first, Mr Chairman?

**The Chair:** Okay, the PC replacement motion on subsections 10(3) to (7). Mr Sterling, would you like to withdraw your former one?

**Mr Sterling:** I withdraw the previous motion on that on section 10.

**The Chair:** Mr Sterling moves that section 10 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsections:

"Functions

"(3) The committee established under clause (1)(a) has the following functions:

"1. To comment on the impact of the advocacy services provided by the commission on the families of vulnerable persons.

"2. To comment on the impact of advocacy services provided by the commission on the providers of health and social services.

"3. To consult and advise on the policies and procedures of the commission.

"(4) The chair of the committee established under clause (1)(a) shall be appointed from among the members of the committee.

"(5) The chair and the other members of the committee established under clause (1)(a) shall hold office for three-year terms and may be reappointed for one further three-year term.

"(6) The committee established under clause (1)(a) shall meet at least four times a year.

"(7) The chair and the other members of the committee established under clause (1)(a) shall be paid the remuneration fixed by the Lieutenant Governor in Council.

"(8) The committee established under clause (1)(a) shall make an annual report to the minister on its activities."

**Mr Sterling:** At the request of the government, I have reworked the motion which I put forward yesterday. In my view, it carries a substantial part of what I wanted yesterday, which includes some kind of formal reporting mechanism and ensures that the committee is at least somewhat active. I would hope that it would be much more active than meeting quarterly, but it puts a bare minimum there and, I guess, gives them some scope of what I would see as part of their function as a committee advising the commission.

**Mr Malkowski:** The motion certainly seems to be very reasonable and valid, and the government has no problem in supporting that motion.

**Mr Sterling:** As all my amendments are.

**Mr Jim Wilson:** We don't have any we don't support.

**Mrs Sullivan:** We support this motion and will be withdrawing the motion that we have put forward with respect to the description of the function of the committee. We feel that this is a real addition to the bill. It certainly follows upon the recommendations which have been put forward to us by many groups and organizations. We feel that the advisory committee, if it has any validity at all, must indeed have a mandate, must indeed have a reporting function, an accountability, and regular meetings which ensure that the work of the committee proceed and is seen to move ahead.

The one reservation I have with respect to the recommendation is it was our motion that the commission would include any reports made to it from the advisory committee as part of its annual report to the minister. What we have here is that the advisory committee itself will make that annual report to the minister. Therefore it will be separate from the activities of the committee and the juxtaposition of the commission's activities and those of the committee which are making recommendations or commenting on advocacy services and providing consultation and advice will be separate and distinct and perhaps may flow at a different time. However, we feel that this is a very useful amendment and we'll be supporting it.

**The Chair:** Further comments? Seeing no further comments, all those in favour of the replacement PC motion on subsections 10(3) to (7)? Opposed?

Motion agreed to.

**The Chair:** All committee members have received the new Liberal motion on subsection 10(2), paragraphs 2 and 3, which will be re-read into the record.

Mrs Sullivan moves that paragraphs 2 and 3 of subsection 10(2) of the bill, as reprinted, be struck out and the following substituted:

"2. Persons who provide care and services to vulnerable persons."

**Mr Malkowski:** We will be prepared to support that motion.

**Mr Jim Wilson:** For the record, we'll be supporting this motion, which clarifies the wording and intent of the section.

**The Chair:** Seeing no further comments, all those in favour of the replacement Liberal motion on subsection 10(2), paragraphs 2 and 3? Opposed?

Motion agreed to.

**The Chair:** At the end we'll go back to the government on section 10.

1640

Section 11:

**The Chair:** Now we'll go to the PC motion on subsection 11(3).

**Mr Jim Wilson:** We just need about 30 seconds on that. We want to change a line.

**Mr Sterling:** I'm going to withdraw my previous subsection 11(3) and substitute therefor:

"The minister shall table the advisory committee's annual report before the Legislative Assembly if it is in session or, if not, at the next session."

In other words, it parallels subsection 11(2) with regard to the commission's annual report.

**Mr Jim Wilson:** The intent really is self-explanatory. It's to ensure the Legislature receives both reports.

**Mr Malkowski:** Could I ask for repetition of the motion, please? Could you just repeat it for clarification?

**Mr Sterling:** "The minister shall table the advisory committee's annual report before the Legislative Assembly if it is in session or, if not, at the next session."

**Mrs Sullivan:** We will be supporting this amendment. It follows fully with respect to the last amendment put forward by the Progressive Conservatives, which we supported. We also feel that the Legislature would be well advised to have that document to understand the workings not only of the commission, but of the advisory committee to the commission.

**Mr Malkowski:** We have some concerns with the wording of the motion. I'd like to ask our policy adviser to comment on that.

**Ms Valentine:** I believe the government intent is to accept the motion, but the wording would probably have to be reworded, and legislative counsel is looking at the wording. It likely would have to say something to the effect of the committee established under clause 10(1)(a). Laura Hopkins will be able to offer some wording in a few minutes.

**The Chair:** Stand this down until legislative counsel can reword it? Agreed.

Section 13:

**The Chair:** In the government reprint, government motion 10, clause 13(1)(b).

**Mr Sterling:** I'm just throwing this out and maybe the parliamentary assistant might want to think about this. The reason we're having difficulty with that section is because the advisory commission has no name. Maybe it would be wise, if they're going to produce an annual report, as we have already agreed, that you might want to enshrine the



advisory committee to the Advocacy Commission or something very descriptive but which would have some kind of tag on it. I just throw that out, okay?

**Mr Malkowski:** Thank you for that comment for consideration.

**The Chair:** On the government motion on clause 13(1)(b), discussion or comments? No comments? All those in favour of the government motion on clause 13(1)(b) in the reprint? Opposed?

Motion agreed to.

**The Chair:** Government motion on subsection 13(4.1) in the reprint. Comments? Seeing no comments, all those in favour of the government motion on subsection 13(4.1) in the reprint? Opposed?

Motion agreed to.

Section 14:

**The Chair:** Government motion on subsection 14(1.1). Comments? Seeing no comments, all those in favour of the government motion on subsection 14(1.1)? Opposed?

Motion agreed to.

Section 15:

**The Chair:** Government motion on subsection 15(1), paragraph 2. Any comments?

Interjection.

**The Chair:** It was a motion moved in committee, not in the reprint.

**Mr Sterling:** We have no problem.

**Mr Jim Wilson:** No problem with that, Mr Chairman.

**The Chair:** Thank you. Seeing no further comments, all those in favour of the government motion on subsection 15(1), paragraph 2? Opposed?

Motion agreed to.

**The Chair:** Government motion on subsection 15(1), paragraph 6, moved in committee. Comments?

**Mr Sterling:** We have no problem.

**The Chair:** All those in favour of the government motion on subsection 15(1), paragraph 6? Opposed?

Motion agreed to.

**The Chair:** Liberal motion on subsection 15(1), paragraph 6.

**Mrs Sullivan:** This motion is put forward in accordance with the expert advice we received before the committee indicating that the section, "Organizations representing persons with a neurological disability, illness or infirmity," should include schizophrenia and therefore the motion is placed before you.

**Mr Malkowski:** The government cannot support the motion for the following reasons: The issues requiring advocacy services for vulnerable people diagnosed as schizophrenic are, for the most part, identical to those of other people with psychiatric or emotional disabilities, and organizations representing schizophrenics fall more appropriately into paragraph 4 than into paragraph 6. Additionally, we don't wish to set a precedent for prolonged debate as to the nature of other psychiatric or emotional disorders.

**Mr Sterling:** I feel that because of the evidence given in front of this committee that over 50% of our beds in our psychiatric institutions are occupied by people who are schizophrenic patients, it certainly deserves in my view the unenviable designation as the predominant psychiatric mental illness that we have in Ontario.

If that is the case, then I think they really do bear being included as a specific part or item of the organizations that are considered under this particular part of it. We heard that 8% of our total health care budget goes to taking care of this one illness. Probably there's no other illness—well, there might be in terms of cancer or heart disease. It's a huge part of our health care budget. It's a huge problem and I think it deserves being distinguished or brought to the fore in either this section or in paragraph 4. I'm sure Mrs Sullivan doesn't really care which section it's in as long as it's recognized.

1650

**Mr Malkowski:** Just to respond to that concern, you've said the beds in psychiatric hospitals specifically, but again those are not neurologically diagnosed patients; those aren't beds for neurological patients. Again, it's psychiatric hospitals.

**Mr Jim Wilson:** I don't understand that.

**Mrs Sullivan:** I think the issue here relates to the way people define themselves and the expertise associated with the illness or disability is itself defined by those who have that illness or disability.

I note that the government has accepted the recommendation of the Learning Disabilities Association of Ontario, which came before us indicating that it would prefer to be categorized under paragraph 6 as a neurological illness, rather than under paragraph 2 with a physical disability that's not readily apparent. The government's acceded to that request.

The Ontario Friends of Schizophrenics have come before this committee and they've indicated to us that all of the expertise, all of the current thinking, all of the approach to the disability or illness of schizophrenia is to recognize it as a neurological disability. They have asked therefore, very specifically, to be included and recognized quite specifically under paragraph 6. I am, on their behalf, because I am convinced by their arguments, putting that forward.

You've been talking about people defining themselves. Well surely, we can accept the advice of people who are involved and accept their definition and include them quite specifically in that section.

**Mr Malkowski:** In response to that, when an individual is schizophrenic, he goes to a psychiatrist; he does not see a neurologist. Also, members of the Ontario Psychiatric Survivors' Alliance themselves have said they are comfortable with category 4.

**The Chair:** Thank you. Further comments?

**Mrs Sullivan:** I didn't understand the last comment from the parliamentary assistant.

**Mr Malkowski:** Persons with schizophrenia themselves are members of an organization called OPSA, the

Ontario Psychiatric Survivors' Alliance, and they support the designation under category 4.

**Mrs Sullivan:** We've had no evidence of that before the committee. The evidence we've had before the committee was a specific request for schizophrenia to be included specifically under paragraph 6.

**Ms Carter:** Maybe this needs to be considered in the light of the government motion that's just coming up, which alters the basis on which this amendment is put; so that the change will be made, but it will not have the effect that was considered.

**The Chair:** Are you referring to 15(2)?

**Ms Carter:** Yes.

**The Chair:** Further comments? Seeing no further comments, all those in favour of the Liberal motion on paragraph 15(1)6? Opposed?

Motion negatived.

Section 11:

**The Chair:** Now we can go back to the PC replacement motion.

**Mr Sterling:** Why don't I read it? It's a short motion and I might as well read it again.

I move that section 11 of the bill be amended by adding thereto the following subsection:

"(3) The minister shall table the annual report of the committee established under clause 10(1)(a) before the Legislative Assembly, if it is in session or, if not, at the next session."

I am advised by legislative counsel that it's not necessary to name the committee in the legislation, that that can be done subsequently by themselves. So my previous point was not irrelevant, but not important.

**Mr Winninger:** Well, at least you referred to a committee established under a particular section, to differentiate it from the appointments advisory committee, for example.

**Mr Malkowski:** We certainly support the motion.

**The Chair:** Further comment? Seeing none, all those in favour of the PC replacement motion on section 11? Opposed?

Motion agreed to.

1700

**The Chair:** As it's 5 o'clock and we still have a long way to go, could the committee give the Chair some indication of how we are going to proceed?

**Mr Malkowski:** We would like to continue and complete the proposed amendments. If it looks like we're going past 6, I would recommend we have a dinner break at 6 and resume at 7.

**Mr Sterling:** I don't want a long discussion about this, but I would prefer that at 6, if it appears we're getting near the end of the road, I'd just as soon continue on. Why don't we judge it at 6 o'clock? We'll not hold the clerk responsible for feeding us until 6 o'clock when we make that decision.

**The Chair:** Any further comments? If not, we will proceed.

Section 15:

**The Chair:** The government motion moved in committee on subsection 15(2). Comments?

**Mrs Sullivan:** I don't think we should proceed to a vote on this without having some explanation from the government of why this entire section is being put forward. We are reaching the point of a circus scenario in terms of quotas for various bits and pieces on the appointments committee and on the advisory committee and on the commission itself. The government is moving another motion which creates another series of quotas about who can do what and when and how and who should be there and so on. The next thing we will have is a quota for a quorum of the commission. I just think this is ludicrous. I would like to hear what passionate reason requires this additional section.

**Mr Malkowski:** I'd like to refer this to our legal counsel.

**Ms Perlis:** The motion accomplishes two purposes. First, it removes the exception previously accorded to the organizations in category 6 under neurological disability, to reflect the new information obtained through the committee hearings that there are in fact groups of persons with neurological disorders who speak on their own behalf and who could adequately represent the organizations from that category in the nominations process.

The second effect of the amendment is to give full effect to the intent that the organizations who are eligible to participate in the nominations process have a membership which is comprised of a majority of persons with disabilities. As the section is currently worded in the reprinted bill, in subsection 15(2), it is possible that the organization represents persons who are family members or care givers or professionals who have an interest in persons with disabilities from the various categories and within the strict interpretation and the wording of 15(2) would therefore qualify.

But it is the government's intent that the only organizations that qualify to participate in the process are those whose membership is comprised of a majority of persons either from the groups or with the disabilities described in the various categories, with the exception of categories 7 and 8, which are given special treatment in the amendment because of the way the organizations are described in the categories.

**Mrs Sullivan:** I suppose that with respect to paragraph (a), we're getting back to the argument put by Mr Baker before the committee, which many of us disagree with. We felt that the first approach of subsection (2) was the appropriate one. I will ask you to explain to me how an organization for autistic people will participate in this process. We know there are enormous strides being made in terms of communications efforts in autism, but this is complicating the whole process to the point of insanity.

**Mr Malkowski:** I would like to refer this to legal counsel.

**Ms Perlis:** Actually, it's co-counsel at the moment who's going to speak to that.



**Ms Carla McKague:** I think there are a couple of things that should be indicated about the wording of the section as revised to do with the neurological category.

First, as Mr Malkowski has already indicated, the government has certainly learned since the original draft of the existence of groups it was unaware of with various sorts of neurological disabilities.

Second, with a number of these disabilities, there is of course a wide range of deficit, if one likes, disability, so that for people with Alzheimer's disease, you have people in the very early stages and still very, very high functioning, and people who are very seriously deteriorated. Particularly with the addition or the moving of learning disability into category 6, we feel there's a very fertile field for very able representatives.

Disabilities such as autism are yet a bit behind, both in therapy and in organizing among themselves, but they're certainly well on the way, and the legislation of course does not require that a person with autism sit on the commission. It requires that if there are organizations of people who are autistic, they have the right to participate in the choosing of the commission.

I would also reiterate that all of those organizations in category 6 are among themselves going to have to come up with two names, and that any groups which may be at a stage of development at which they're not yet able to participate as fully as one would like in that process are not going to have undue weight in the selection of the final two candidates.

**Mr Sterling:** I'm amazed at how careful the government is being with regard to the selection of the appointments advisory committee, which I presume is going to have a function that is going to be somewhat limited and for a very short duration. I guess there comes a time when you're drawing legislation that you have to think about people who might want to read this stuff and try to understand what you're driving at.

If the minister were not satisfied that a nomination came forward that was representing a group or a legitimate group or a group that was not intended to be represented on the advisory committee, she in this case only has to take eight of these people. Presumably, she's going to have 24 different nominations. I mean, you don't seem to be that concerned about some of the qualifications about what advocates must be, but we're concerned about who is going to be on a committee to place people on the commission and their job. I guess it will take one meeting every two years or one meeting every year, and we're writing legislation which is extremely complicated. The care you're taking for the job seems to me extreme at the very least. I believe that the minister has enough discretion to ensure that every nomination that's coming forward is from a legitimate group representing a legitimate interest that she wants on that commission.

I must say there is some sense to the section, but it's just how complicated you make it for what I consider is an advisory committee which isn't going to really decide anything except who's going to be on another committee. I don't know how long you go on.

1710

**The Chair:** Further discussion? Seeing no further discussion—

**Mrs Sullivan:** It's just so nonsensical that no further discussion is necessary. We will clearly be voting against this. This is just ludicrous.

**The Chair:** Seeing no further discussion on the motion moved in committee by the government on subsection 15(2), all those in favour? Opposed?

Motion agreed to.

**The Chair:** It seems we missed one amendment in the reprint. Government motion in the reprint, paragraph 15(1)7, the underlined section. Any discussion?

**Mrs Sullivan:** Yes, could the parliamentary assistant speak to what is intended to be added in this section?

**Mr Malkowski:** I'd like to ask legal counsel to expand on that.

**Ms McKague:** This amendment is really again a clarifying amendment. As originally drafted in error, one must admit, they said organizations representing persons with multiple disabilities, of which obviously the clearest reading is an organization such as, for example, a deaf-blind association for people who each have more than one disability.

That was not the intent. The intent was to involve organizations such as PUSH, for instance—Persons United for Self-Help in Ontario—which represent people all of whom are disabled but who have differing kinds of disabilities, so some members are blind, some members are in wheelchairs and so on. It's simply to clarify that cross-disability organizations was the category that was meant to be included as category 7.

**The Chair:** Further comments? Seeing none, all those in favour of the government reprint on paragraph 15(1)7? Opposed?

Motion agreed to.

**The Chair:** On Liberal motion 15.0.1 to 15.0.3.

**Mrs Sullivan:** I have a replacement motion which has been distributed.

**The Chair:** You withdraw the other one?

**Mrs Sullivan:** Yes, I withdraw the original motion. I have to read this into the record, correct?

**The Chair:** Mrs Sullivan moves that the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following sections:

"Advocacy review board

"15.0.1 (1) A board to be known as the advocacy review board is hereby established.

"Functions of the board

"(2) The board has the following functions:

"1. To consider complaints relating to the conduct of advocates who provide advocacy services on behalf of the commission.

"2. To hear appeals from decisions of or findings of advocates.

"3. To consider complaints relating to the commission's performance of its functions.

"4. To hear appeals from decisions or findings of the commission.

"5. To issue directives concerning the circumstances in which advocates are required to provide the advocacy services required under the act.

"Powers of the board

"(3) The board has the powers necessary to perform its functions and, in particular, may,

"(a) investigate and hold hearings into complaints;

"(b) impose disciplinary measures against an advocate that the board determines has acted improperly,

"(c) substitute its decision or finding in a matter complained of for that of the advocate or commission and direct a course of action to be followed.

"Procedure

"(4) The chair of the board may make rules governing the procedure to be used in hearings before the board.

"Composition of panels

"(5) The chair shall determine the composition of each panel of the board that holds a hearing relating to a complaint or an appeal. A panel may consist of either one or three members, as the chair determines.

"Composition of the board

"15.0.2(1) The board shall consist of such members as may be appointed by the Lieutenant Governor in Council.

"Ineligibility

"(2) A person is not eligible to be appointed as a member of the board if he or she is employed,

"(a) by the commission;

"(b) by a community agency that provides advocacy services to vulnerable persons;

"(c) by an organization that provides health care, housing, or vocational or other services to vulnerable persons; or

"(d) at a facility.

"Chair

"(3) The Lieutenant Governor in Council shall designate one member as chair and one or more others as vice-chairs.

"Service

"(4) The members shall serve on a part-time basis.

"Term and reappointment

"(5) The members shall hold office for three-year terms and may be reappointed.

"Vacancies

"(6) If a member's position becomes vacant, the Lieutenant Governor in Council may appoint a replacement to serve for the remainder of the member's term.

"Same, chair

"(7) If the chair is unable to act for any reason, a vice-chair may act in his or her place.

"Remuneration and expenses

"(8) The members shall be paid the remuneration fixed by the Lieutenant Governor in Council and the reasonable expenses incurred in the course of their duties under the act.

"Staff

"(9) Such employees as are necessary for the proper conduct of the board's work may be appointed under the Public Service Act.

"Complaints to the board

"15.0.3(1) Any person may make a complaint to the board in writing,

"(a) about the conduct of advocates who provide advocacy services on behalf of the commission; or

"(b) relating to the commission's performance of its functions.

"Appeals

"(2) Any interested person may appeal a decision or finding of an advocate or the commission by giving notice in writing to the board.

"Consideration by the board

"(3) Upon receiving a complaint or notice of an appeal, a panel of the board shall hold a hearing into the matter and make a decision.

"Legal representation

"(4) A party to a hearing and any witness participating in the hearing is entitled to be represented by a lawyer at the hearing.

"Compliance by commission

"(6) The commission shall comply with any directions issued to it by the board relating to a complaint.

"Publication of decisions

"(7) The board shall provide a copy of its decision following a hearing to persons who request a copy."

**Mrs Sullivan:** Mr Chairman, the intent of this motion is quite clear. Throughout the hearings and in the intersession and any discussions relating to the Advocacy Commission and the services of advocates which would be provided thereunder, we have heard great concern about the powers of an advocate to intervene in people's lives, the power to determine their vulnerability, the power to access their records, the power to enter private premises, the power to participate in an interventionist way.

For the most part, I think most of us believe that those powers will be used responsibly. There may be instances, however, where indeed they're not used responsibly, where indeed an advocate is not operating in a manner in which the vulnerable person, or a person representing the vulnerable person, is satisfied that ethical standards are being maintained, that the advocate is qualified to make judgements in certain areas. As a consequence, the independence of a complaints body and a review body was felt by many people to be extremely important.

1720

You will note that our recommendations are that the body be a part-time body because in fact we believe that the numbers of complaints and the numbers of reviews requested will in fact be limited. But we do feel very strongly that there must be a body that is able to act and is able to act with independence from the commission in terms of reviewing the issues and determining whether or not an advocate has appropriately responded to a situation, has contravened either the law, for example, by making decisions on behalf of a vulnerable person, or has exceeded powers or used them in an unhappy or inappropriate manner.

We felt that the board must be independent of the commission. I believe that the Progressive Conservative recommendation in this area suggests that there be a separate complaints review committee under the commission. The



commission itself has significant power and in engaging in some activities perhaps relating to systemic advocacy may engender complaints and concerns that should also be reviewed by a review board that is independent in itself of the commission.

We know that there has been, in virtually every day of our public hearings, at least one presenter and frequently more who are very concerned about the lack of independent review procedures with respect to services provided by advocates and by the commission. We've modelled the board in a responsible way, in a way that includes simplicity and where the mandate is very clear. I am sincerely hoping that the government will support this amendment. We really believe it's an important one.

**Mr Jim Wilson:** While agreeing with the thrust and the principle behind this motion as put forward by the Liberals, we don't really support it in terms of setting up another independent review body. Members will note with the PC motion pertaining to this new section that our model is similar and parallels that which we saw in the Regulated Health Professions Act, at least in principle, where the commission itself should have a review process, a complaints process, an appeals process and body where the public can bring complaints or concerns and where decisions of the commission can be reviewed on sober second thought as it were. We don't find it necessary to set up another independent body to do that. We trust many of our professional colleges to do this work internally and we'd like to see a similar structure for the advocacy commission.

**Mr Malkowski:** We will not be able to support this motion. We feel this review process is overly complex and inappropriate, being based on a professional discipline model.

**Mr Jim Wilson:** Having heard that, what is the government's intention in this area? If you don't support the Liberal review board model, are you intending to support the PC motion that will follow? I think it's important that we hash this out now, given that I think Mr Malkowski indicated a willingness there to have some sort of review process in place, an appeals process.

**Mr Malkowski:** This process would be too complicated.

**Mr Jim Wilson:** Then what do you suggest? We heard, as Mrs Sullivan very correctly stated, witness after witness after witness calling upon all of us to think good and hard about what type of accountability is in here for advocates, and where would the public go, and how would their complaints be dealt with and who would review the decisions of the commission? These are very serious questions that can't be sloughed off. We—and the Liberal Party agrees, of course—are not willing to let these important matters be dealt with simply in regulations.

**Mr Malkowski:** I appreciate the concerns you have raised. One of the things we are certainly willing to consider is using a model from the Child and Family Services Act; that's a model we could see being useful. Maybe I could refer to our legal counsel to expand on that.

**Ms McKague:** Perhaps preliminary to speaking precisely to the CFSA model, we could reiterate the govern-

ment's concern that the motions that have been brought forward seem to indicate the idea that an advocate is going to be carrying out an occupation which is very similar in its structure to professions. This is not the case. Doctors have their licences removed and cannot practice medicine. An advocate who has his or her authorization removed will still be able to be an advocate. The professional discipline model just isn't effective when using disciplinary processes does not affect the person's livelihood.

It seems more appropriate to work within the standard employer-employee kind of model, with suitable safeguards. We're looking very seriously at expanding the current provisions in the bill which say that the commission will develop a complaints procedure, to giving the commission some guidelines. This is not yet an undertaking. I'm putting this forward as something that we're considering, and the proposed section on which this would be modelled is section 64 of the Child and Family Services Act, which provides that a children's aid society:

"Shall establish a written review procedure, which shall be approved by a director, for hearing and dealing with complaints by any person regarding services sought or received from the society, and shall make the review procedure available to any person on request.

"(2) A review procedure established under subsection (1) shall include an opportunity for the person making the complaint to be heard by the society's board of directors.

"(3) A person who makes a complaint and is not satisfied with the response of the society's board of directors may have the matter reviewed by a director."

This provides an opportunity for complaints and an opportunity for a hearing before the board of directors, which presumably, in the case of the commission, would be a hearing before the commission, and a review—just a moment. I want to check with co-counsel here. My friend advises me that in fact there's been some modification to this and that the original complaint would be heard before a committee composed of members of the commission and of the advisory committee, and that there would then be a review available to the chief commissioner. This is a model that we could flesh out a little, should we decide to proceed with it, but one that is much simpler, much easier, does not set up complicated new structures and doesn't fall into the trap of thinking that professional discipline is necessarily the best way to deal with an advocate who is not fulfilling his or her duties appropriately.

1730

**Mr Jim Wilson:** With due respect, I disagree that a professional discipline model is not appropriate. I found most of that mind-boggling and in fact unbelievable, in terms of the premise being that advocates aren't some sort of profession. Does the government truly believe that with this legislation, it's not really establishing the new profession of advocates? I think they are. I think many witnesses who appeared before this committee believe that.

Certainly I can see no other evolution down the road other than that we'll be teaching in our community colleges and universities professional advocacy at some point. It will almost be necessary with this legislation, especially



the vagueness of this legislation, if advocates are to truly do their job and carry out responsibilities and to have the public confidence necessary to carry out the responsibilities, because there are tremendous responsibilities and powers given in this legislation. I think we can come to no conclusion except that the natural evolution of this is a professional body of advocates. To slough this off at this point and for the government not to bring forward a specific amendment to the legislation dealing with an appeals procedure and a discipline model of some sort is, frankly, mind-boggling.

I'm going to stop there, because I know Mrs Sullivan wants to carry along the same line of comment, but I really am shocked that we're in clause-by-clause, and the government knows of our concerns, knows of the many witnesses who expressed similar concerns, and yet we have nothing before us to deal with this. We're given platitudes and nothing concrete from counsel, no comment at all from the parliamentary assistant, no assurances from the government. Frankly, my experience in two years is to not take you at your assurances but to ensure that we see something concrete, in writing, and that we actually vote on matters.

I'll leave it at that. I'm sure we'll want to comment further.

**Mrs Sullivan:** There are two points I want to make. One is in reference to the response from the parliamentary assistant for the Minister of Citizenship. He suggested that the process being recommended in my amendment was too complicated and, by inference, that the process being recommended by the Progressive Conservatives was too complicated.

Think back to about four and a half minutes ago, when we were dealing with an absolutely wacko proposal of categories, subcategories, intervening categories, for one purpose only, and that is to gather people together to make recommendations for other people to sit on a committee. If you want to see complications, look at what the government has designed in its headiness for the composition of the advisory committee on appointments.

What I am recommending is absolutely straightforward. Depending on the need, the government can appoint as few as perhaps five or six part-time people. If there are numerous complaints, the government has, through the Lieutenant Governor in Council, the freedom to appoint additional numbers. The process is a simple process. People who have a complaint bring their complaint to the board, which may only have one employee, which may, depending on the requirements of the process, have more than one employee. A panel of one or three people reviews that complaint, makes determinations as to whether the advocate acted properly, makes determinations about whether the commission acted properly, makes a decision, and it's over. It is totally independent from the commission, which is extremely important, because the commission itself may be the subject of complaint.

We don't know now, because we haven't got the information from the government, precisely what the scope of the work of advocates will be. We don't know, therefore, the nature of the scope of the kinds of complaints that can

arise if there are problems with the work they're doing. This is a very straightforward proposal.

As I complete my remarks I want to move on to the observations made by counsel to the Minister of Citizenship. I want to tell you, it is outrageous that the government is now, while we are in clause-by-clause consideration of these bills, musing about a new policy determination about some new kind of guideline about how a complaints process would operate.

What have they been doing? This legislation has been on the table for months. There have already been 200 amendments put forward by the government. Between the opposition parties, we've brought forward about 50. What on earth have they been doing? We are in clause-by-clause. We are down to the short strokes here. What is going on?

**Mr Winninger:** Just briefly, I don't find the government's position at all mind-boggling here. A reference was made to professionalism. Certainly children's aid workers are professionals, and they have a much less cumbersome and complex complaints procedure under the Child and Family Services Act.

If the opposition is serious in its quest for a complaints procedure here, why can't the opposition, either party, put forward a much simpler mechanism, similar to the one in the Child and Family Services Act for a complaints procedure? Surely children are entitled to the same attention and respect that vulnerable people are, and if a simpler complaints procedure is adequate and appropriate under the Child and Family Services Act, surely it would serve us well to look at that here.

I would also say that we're not dealing with questions of professional licensure here, as we would be in the case of other professional bodies, so the same kind of considerations that apply to some of the self-governing professions may not be applicable here. I don't see why you don't put forward something a little simpler, a little more straightforward, that doesn't require a cumbersome mechanism and structure.

I don't think it behooves the opposition to ask, why has the government not done this sooner? We've been responsive at all stages to concerns that have arisen, and amendments are being made as we go through clause-by-clause. I don't think you can have it both ways. You can't say, "This government doesn't care about some of the positions that are put forward," and then say: "The government is responding to some of these positions put forward. Why are you doing it now instead of earlier?" I don't think you can have it both ways.

**Mr Malkowski:** I certainly appreciate the concerns that have been raised by both the PC and Liberal parties. Just for clarification, we are not going to be able to support your two motions as they stand. However, we would certainly consider it if either party were to develop an amendment using, as mentioned, a model similar to the Child and Family Services Act model.

1740

**Mr Jim Wilson:** I think, to take a rational approach to this problem, we should perhaps agree to stand down this motion and the PC motion. I do take offence at both the



parliamentary assistant and Mr Winninger putting the onus on opposition parties to come up with the exact wording of a complaints procedure process as fundamental as simply accountability for advocates in the commission. That's a poor excuse, and if you think that's going to wash in the public, you've got another think coming.

We have extremely limited resources as opposition members. We have been given the tightest time frame that, in my nine years around this building—two years as elected and seven years as an assistant—in politics, I've never seen such a workload put on legislators as this legislation has required, in addition to all the other regular duties we have as representatives of the people in our ridings and in our critic responsibilities, in such a tight time frame.

You're the ones with the thousands of bureaucrats whom you can call upon to help you with government business. You should not be pretending to be surprised that this would be a concern of the opposition parties, if you were listening at all during the public hearings. You cannot pretend to be responding to what you heard during the public hearings and then simply say that because we brought forward motions too complicated, in your words, that's your excuse and you're going to rest on that and, therefore, nothing will be done.

I think this should be stood down. We've done our best. We've put in writing what both opposition parties feel would be a fair review process, both a review board and a complaints review committee, and the onus is on the government to come forward with what it feels will be a workable compromise.

I think that it's only fair as humans—because we've been very cooperative to date with the dictates that have come from the Legislature through your party. The fact that we're still sitting here and putting up with this, I think is a real credit to both our patience and our willingness to cooperate and try to be responsible legislators. To be told that somehow we're irresponsible and not putting forward workable amendments, frankly I take exception to and throw the ball back in your court. I want to hear exactly what the government intends to do in this area.

**Mrs Sullivan:** I will probably reiterate some of the statements that have been made by Mr Wilson. But I can tell you that I'm very angry that on these bills, which have singular public importance, we are operating under a time allocation, we have seven days for the consideration of four bills that will affect every single person and every single health care practitioner in this province. We now hear that fairly simple proposals and principles for a review procedure have been described as too complicated but that none the less it is the obligation of the opposition to come forward with a complaint process that people have been demanding through the entire public hearing process.

I was discussing yesterday with one of the new people who've been hired by the ministry or the minister to deal with the Advocacy Commission. She indicated to me that there are 18 people in the minister's office working on the implementation of this act. This bill has not passed yet. We are still in committee. We are in clause-by-clause. Eighteen people working on the implementation of this thing already, and the government can't even come up with

an amendment on how we're going to deal with complaints about advocates or complaints about the commission, when people were before this committee during the first hearings and the second hearings saying it was a necessary part and a necessary change required. I cannot believe what I'm hearing. I am so angry about the approach of the government in this area.

You can take all the credit you want for being responsive; the legislation was so badly drafted in the beginning that you had to be responsive.

**Mr Malkowski:** I'd like to respond to the seriousness of the concerns that have been brought up by both the Liberal and PC members. I do think that it's important to say very clearly that we're not going to be able to support either motion. However, we will very seriously consider the concerns that have been raised and will bring those concerns to the minister's attention for further consideration on this matter.

**Mrs Sullivan:** I would like to stand down my motion.

Where is the minister? Why couldn't the minister be here to deal with these issues on her own? We've asked that. As a full committee we asked that. She's in retreat. Well, that's great.

**Mr Sterling:** She has been in retreat for some period of time on this bill.

**Mrs Sullivan:** That's for sure. She doesn't know what's going on.

**The Chair:** Mr Wilson said to stand down both the Liberal and PC motions?

**Mr Jim Wilson:** That's correct, Mr Chairman.

**Mrs Sullivan:** I will stand down mine.

**The Chair:** Do we have unanimous agreement to stand down both?

**Mr Malkowski:** No, we will not support standing down the motion.

**The Chair:** We don't have unanimous consent to stand them down. Further discussion?

**Mr Malkowski:** The concerns are very serious, and I certainly will bring those concerns to the minister and we will consider developing an amendment that will respond to those concerns. I think we should call the vote on this.

**Mrs Sullivan:** Mr Chairman, throughout this committee we have cooperated in terms of requests from the government to stand down motions. We understand that the government indeed will have further requests to stand down motions as we proceed through this bill. We are making a simple request so that if replacement motions can be developed, they will be. We do not understand why the government refuses unanimous consent when we have been giving consent to the government to stand down issues. Where is the cooperation here?

**Mr Owens:** Mr Chair, I'd like to request that the parliamentary assistant reconsider his stance with respect to not standing down these two motions. As Ms Sullivan and Mr Wilson have indicated, we have in fact worked fairly well, albeit a little sparky from time to time, but I think that these issues are serious and that we need to take a look

at that. I again would ask the parliamentary assistant to reconsider his stand.

**Mr Malkowski:** All right. I am willing to reconsider that issue and I do agree that we stand down the motion.

**The Chair:** Do we have unanimous consent to stand down the Liberal and the PC motions? Agreed.

Does this committee wish the clerk to order in dinner?

**Mrs Sullivan:** Given the response of the government with respect to the last amendments which were put forward, we may have some work to do over our dinner hour and I would frankly prefer to take a break to do that, so that we can have an amendment that may be acceptable to the government, since the government doesn't seem to be able to take its own responsibilities.

I would also like to recommend that we break for supper now. I think that we're moving to a section of the bill which will require some discussion with respect to the capability of instructing an advocate, and I think it might be useful if we broke now and perhaps returned at 7.

**Mr Malkowski:** I think it would be helpful if we at least ordered food in, and I agree that we should adjourn until 7 o'clock and resume at 7.

Interjections.

**The Chair:** All right. This committee will stand recessed until 7 pm.

The committee recessed at 1751.



## EVENING SITTING

The committee resumed at 1932.

**The Chair:** I call this meeting back to order. We will now be going to a Liberal motion on subsection 15.1(1.1). Any comments?

**Mrs Sullivan:** I think that when we look at the sections of the bill, we're dealing in these amendments which are before us with the provisions for uninstructed advocacy. I think we all know that there are some delicacies involved in this area, and one of the things that's of concern in relationship to the bill as it's drafted is that the definition of the capacity to instruct an advocate or for the advocate to determine that the vulnerable person is in fact incapable of providing that instruction, or capable of providing that instruction, has been left out. The bill is silent in those areas.

I think we know that the government recognizes that in fact there is a gap here because the government itself has put forward a motion, not in the same place that I did, but it happens to follow, which is fairly useful. The government's motion is subsection 15.1(4). I've put my motion forward in subsection 15.1(1.1) to include a statutory guidance for the capability of the vulnerable person to instruct an advocate.

What I have done is to look back at the common law with respect to capacity to bring forward my amendment, indicating that in order to instruct an advocate, the vulnerable person should understand the information that's relevant to giving the instructions in the circumstance and to appreciate the consequences of those instructions.

By definition earlier in the bill, a vulnerable person is a person who is physically or mentally disabled and who is unable to express his wishes or ascertain or exercise his rights or who has difficulty in doing so. One of the very issues then becomes that the vulnerable person is less vulnerable in being able to provide the instructions or to have a will, to have an intent. The difficulty comes in exercising and communicating what that will is and in achieving rights with respect to the expression of that will.

My definition provides a dignity to the vulnerable person in that in the first section it provides an indication that the person, who is defined statutorily earlier, is not only disabled and so on, but gives the benefit of the doubt to the person that he, while disabled, while unable to express his wishes, while having difficulty in doing so, is none the less able to understand the information and the consequences of the factors that are a part of providing instruction to an advocate.

The second part of the capacity or capability to instruct that I've included in my amendment relates to the capability of the vulnerable person to express in some manner his or her instructions or wishes. We know that the communication of disabled people, depending on the nature of the disability, can vary. We learned about many new methods of communication, for example, that people associated with persons who have autism are developing and that in fact may provide a new vehicle for communication, but there are other methods. There can be writing, there can be

Braille, there can be machines, there can be computers, there can be American sign language and there can be a number of methods of communication that in fact respond to the issue of having difficulty in expressing the wishes or the will or in exercising rights.

We feel that the capacity to instruct is an important part of the bill. In my view, even with the addition of the government motion in this area, our definition in fact would stand. They could work in combination as part of the same section if the government wanted to do that. We feel that it reflects more closely the common law than does the government motion and recommend strongly government support for this amendment.

**Mr Malkowski:** I appreciate the concerns that have been raised and the points that you've brought up. The government is not going to be able to support the motion, however, because we have already introduced what we feel is a more appropriate definition of capacity to instruct an advocate.

**Mrs Sullivan:** There is no conflict between the motion that I have put forward and that which the government has put forward; indeed, they could both work in tandem. The government's motion indicates that the vulnerable person, to be capable, should be able to indicate a desire for advocacy services. That would work in tandem with ours. In fact, if anything, it's more limiting than the amendment which I've put forward.

There is no conflict between the two amendments and in fact they could work well together. My amendment reflects more carefully existing common law with respect to capability or capacity, understanding that the information in my motion indeed could include what the government has included in its amendment, which is an indication of a desire for advocacy services.

**Mr Malkowski:** I'd like to ask our legal counsel to respond to Mrs Sullivan's concerns.

1940

**Ms Perlis:** I certainly would agree with you that your test is much closer in reflecting the common law standard of capacity. The government feels that the common law standard of capacity is more appropriate to a lawyer-client relationship than an advocate-client relationship.

The differences between the two relationships turn on what an advocate can do for a client as compared with what a lawyer can do for a client. An advocate merely stands in the shoes of the client and can really only do for that person what he or she could do for himself or herself, whereas a lawyer has a particular expertise. Lawyers can institute an action. The consequences to the client are potentially far more severe, such as incurring the costs of an action which turns out to be unmeritorious in the eyes of the court and so on, whereas the advocate is really speaking in the shoes of the vulnerable person.

As such, we feel the appropriate test is that the vulnerable person is able to indicate a desire for advocacy services, that he wishes help in some way, and that the

purpose, that is, the outcome, is something he is able to indicate. I think one of our difficulties with the Liberal motion is the notion of reasonably foreseeable consequences, which I think we feel is perhaps too complicated or too high a standard in situations where the person knows the end result he wants and it's sort of simple and clear.

The consequences are not as far-reaching as perhaps they might be if, for example, you have to explain to a client the consequences of issuing a petition for divorce. All the advocate can do is ask for or argue for or negotiate for the very same thing that the client could go and ask for.

**Mrs Sullivan:** I think, given the powers that are provided to the advocates under this act—the power to access clinical records without instruction; the power to enter private residences and residences in which more than one person lives without consent; the power, in this case, when there is no instruction, to take actions perhaps without even knowing what the nature, will or intent of that person is—it could include, for example, if the decision of the advocate is that publicity is the only way to attack a particular issue, without any instruction or concurrence from that vulnerable person, to proceed and take an issue to the press.

We certainly have concerns which will be expressed later with respect to access to documentation. As you know, we have raised issues and have an amendment put forward with respect to health records. There are entire other sets of records that this bill would enable advocates to have access to, in this case, without the consent of the person, without the express instruction or expression of will of that person, because the person is apparently incapable of expressing those instructions.

I think the government's motion on its own is pretty loosey-goosey. If you want to say, "Yes, I want an advocate. I want an advocate to come in and help me deal with a problem," that is what the government says is the test for a vulnerable person in dealing with an issue he is having a difficult time dealing with on his own, without someone who can assist in speaking for him or in accessing services or achieving certain rights.

But that isn't enough. If a person is capable of instructing, he should be capable of not only saying, "Yes, I want to see an advocate," but: "I want the advocate to proceed in a certain way. I understand that these are the circumstances surrounding what I want him to do on my behalf, because I can't do it myself, and I want him to understand that I know certain actions he will take, for example, going to the newspaper with my story, perhaps will affect my life for ever."

I think in fact my test is a far more reasonable test of capacity than the government's is. The government's is not adequate. It could be, as I say, appended to my own as an additional section, but it is not enough to protect the vulnerable person.

**Mr Malkowski:** Perhaps legal counsel can follow up on that.

**Ms Perlis:** I think one of the concerns that's reflected in the motion is if the test for capacity to instruct is too

high, there will be a number of people who are unable to meet the test and yet certainly don't fall within the serious harm criteria for non-instructed advocacy, and we certainly wouldn't want those people to be recipients of non-instructed advocacy services, because they are able, perhaps not to meet a capacity test but to indicate wishes, preferences, ideas and outcomes that would nullify any sort of non-instructed advocacy.

I think the concern is that there be some provision to meet the needs of people whose life experience and ability to meet such a cognitively high test would disqualify them yet who certainly can give the kind of instructions that are the subject of the intent of this act.

I'd also just like to make the point that an advocate cannot within this act do anything against the instructions or wishes of the vulnerable person. If the vulnerable person were to say to the advocate, "I don't want you to go to the press," then it would be incumbent on the advocate to explain, I think, to the person what he was going to do. In an instructed situation, he couldn't do that above the objections of the vulnerable person.

**Mrs Sullivan:** But we're dealing precisely with that scenario, where a person is incapable of instructing the advocate not to go to the press. In fact the advocate will be able to operate in an independent manner, putting himself in the shoes, as you describe it, of the vulnerable person, but clearly without any instruction and in fact protected by the act.

**Ms Perlis:** But not if we have a lower threshold for instructed advocacy. In that situation, more people will be caught within instructed advocacy and the limits imposed on the advocate.

**Mr Sterling:** Who makes the determination whether a person is vulnerable or not vulnerable?

**Ms Carter:** I think maybe by asking that question you've shown what is wrong with this, that we're going to have to measure. The point is that if a person is capable of having wishes and being able to communicate, then he or she qualifies for advocacy without any further test being required.

**Mrs Sullivan:** That's not the question.

**Ms Carter:** The point is very well made that the sole function of an advocate who is being instructed at whatever level is to carry out the wishes of that person.

**Mr Sterling:** In the ideal world, it would be nice to believe that an advocate was always going to act in the best interests of the vulnerable person.

**Ms Carter:** There's a difference between best interests and wishes, and that's one of the differences we're making here.

1950

**Mr Sterling:** In terms of the vulnerable people we're talking about, we're talking about a whole range of individuals. We can have people who understand to a limited degree what is happening to them, we can have people who understand to a very great degree what is happening to them, like the Justin Clark situation, or we can have



people who have very little comprehension of what is happening to them.

If we take the higher end of the scale of people who don't understand very much about what is happening to them, it puts the advocate in a very strong position in terms of his role in what is going to happen to this vulnerable person. Therefore, if it sort of starts to switch the balance as you go up the scale, you start to get into the area of who in fact is controlling the situation. In my view, it would take a very strong advocate to resist the temptation to put his wishes in the shoes of the vulnerable person.

So the control over the advocate is very important and there is nothing in this act as it is now stated where the advocate has to justify his decision in stepping in in terms of those upper decisions. In other words, if he thrusts himself upon a vulnerable person who is at or near the far end of the scale, who does not have the ability to repel or to question the advocate, we're into serious problems.

**Ms Carter:** Then the advocate is contravening the very basis of what he's being asked to do by this act.

**Mr Sterling:** Who's going to put the check on him, Jenny?

**Mr Owens:** Is that the point of the amendment? What we're talking about is a test for a person to be able to instruct an advocate. I don't understand where you're going with your—

**Mrs Sullivan:** The test results in the advocate acting independently of the person because the person is not instructing the advocate.

**Ms Carter:** But that's not permitted. That's not part of this act, except in the case—

**Mrs Sullivan:** How are you going to anything else?

**The Chair:** Order, one at a time. Mrs Sullivan.

**Mrs Sullivan:** I'd like to start with the question that Mr Sterling asked: Who determines if the person is vulnerable? Frankly, the advocate is going to determine if the person is vulnerable. We know that; that's one of the powers of the advocate.

Next, who is going to determine if the person is able to instruct the advocate? The advocate is going to determine that. Who is going to then be acting for that person, in his shoes, if you like, but without any knowledge because there has been no expression of the will of the person? The advocate.

Those are the issues and whether the wording, Jenny, is in the best interests of the person, whether that's the concept or whether the concept is standing in for that person, none the less, the advocate, who may be meeting that person for the very first time, may have absolutely no knowledge of what the will of that person is.

It seems to me that the test for who is incapable or capable of instructing the advocate should be a very high one so that the advocate doesn't have the authority to simply prance in and make decisions and take actions or whatever in the shoes of the person without having moved to the absolute maximum to ensure that that person in fact is capable of expressing his wishes, expressing his will,

about the nature of the action that's going to be taken in his shoes.

**Ms Carter:** When you say "in his shoes," I'm not quite sure what you mean, because what we're assuming is that that person can in fact express some wishes; otherwise, he's not a fit subject for advocacy, unless he is in a state of dire peril, which is the exception we have made to that.

**Mr Malkowski:** Responding to Ms Sullivan's and Mr Sterling's questions, there are three points that I think need to be raised. We have to clarify that the advocate can only act when there is a risk of serious harm, if he or she is acting without instruction. So if an individual does not want an advocate, he or she can simply tell him or her to go away, and it's a very simple case. The advocate follows those people's wishes.

Maybe you can look back at subsections 15.1(3) and 15.1(2). Subsections 15.1(2) and 15.1(3) do not apply unless the advocate has taken all reasonable steps to determine whether the vulnerable person is not able to instruct the advocate.

What we're saying is, when you're talking about setting up a test of capacity, that in fact can limit the vulnerable person's ability to express himself or herself. We don't want to set up a more limiting test. In fact, we want to make sure that the vulnerable person is given all reasonable steps to express himself or herself. So the test for capacity should not be limiting in any way.

**Mrs Sullivan:** I think that what the PA to the minister has said there is very interesting. We have in subsection (2) a requirement that the advocate may provide advocacy services, which can take a variety of courses, to a person without instruction if that person (a) cannot instruct the advocate. That is where, in fact, the capability of instructing the advocate should kick in.

I'd give you the example of a person who is physically disabled and is unable to take some action as a result of that disability. That person may also be fully capable mentally of instructing the advocate and in fact that might be the situation with most people. Where a person is unable to understand the information that's relevant to the instructions, there is an additional disability involved there.

At that point, the advocate has another clear test. There is not only the physical disability, which may make it very difficult for the person to communicate, but also a question of mental capacity which may mean that it is difficult for the person or that the person cannot understand some of the issues associated with the instructions.

The reason we're very concerned about this is that we see that the advocate will be able to act, despite the provisions of the bill that the advocate can't make decisions on the person's behalf. The advocate's defence to that question will be, "Well, we were acting by standing in the shoes of the person, by putting ourselves in the place of the person on his behalf."

In fact, unless the capacity to understand the instructions is there, there should be an additional onerous duty on the advocate to ensure that the instructions and the will



of the person are paramount. It's more than a matter of saying, "I want an advocate." It's a matter of saying, "I want an advocate to assist me in certain areas."

**Ms Carter:** And that's what we're saying in our amendment.

**Mrs Sullivan:** It's not what you're saying.  
2000

**Mr Malkowski:** I think we have agreed that there is a very heavy requirement for the advocate to make every possible effort to communicate with the individual, and People First has expressed its concerns on that issue.

**Mrs Sullivan:** Mr Chairman, I'm getting nowhere here; we might as well move on.

**The Chair:** Further comments?

**Mr Wessinger:** Before we vote on this, I was just looking at the Liberal motion and also our motion. I think a combination of the two might be possible, which would read as follows, and I'll just throw it out for thought:

"A vulnerable person is capable of instructing an advocate if the person is able to indicate a desire for advocacy services and is able to express, in some manner, his or her instructions or wishes."

If the problem is with the latter part of the government motion, that seems to me somewhat more precise.

**Mrs Sullivan:** Can you review that again? You'd go with 15.1(4) as put forward by the government?

**Mr Wessinger:** Yes, for the first part.

**Mrs Sullivan:** And then move to my 15.1(1.1)(b)?

**Mr Wessinger:** Yes.

**Mrs Sullivan:** Well, it's an improvement. Perhaps we can have counsel do a draft on that and stand this section down.

**The Chair:** Stand them both down?

**Mr Wessinger:** Yes.

**The Chair:** Agreed? Agreed. That will be subsection 15.1(1.1), the Liberal motion, and subsection 15.1(4), the government motion.

**Mr Jim Wilson:** May I just make a comment on that? Having reviewed the summary of recommendations from the groups, I think what's key in the Liberal motion and what makes it so important is the ability or some capacity to understand the advocacy services being offered and the information relevant to that. I hope the government will keep that in mind in drafting compromise paragraphs.

**Mr Wessinger:** If I might just respond and give an example of the situation we're going to deal with, an example would be of an elderly patient in a nursing home whose sheets are not being changed often enough. She could express a wish to an advocate to have something as simple as that dealt with. It's to ensure that type of situation does get dealt with; that's the type of situation we want to ensure is covered, that this person would get the advocacy services, a very simple advocacy service, really, but I think very important to the individual.

**Mr Jim Wilson:** Doesn't that imply some understanding on behalf of the elderly person that lying in soiled sheets is not good for him? Having had the opportunity to

listen to the debate that has gone full circle since I've returned from dinner, I think we are on similar but separate wavelengths. I hope you understand the importance of the term "understanding" in the Liberal motion.

**Mr Wessinger:** I should clearly indicate that my suggestion of a compromise motion was because—

**Mr Jim Wilson:** But it's a hollow compromise.

**Mr Wessinger:** —there's some concern expressed about imprecision of language and the purpose for which he or she wishes to receive the service. I think it means the same thing as is set out in Ms Sullivan's 15.1(1.1)(b), but perhaps it is a little more precise from a legal point of view.

**Mrs Sullivan:** No, I think there is another issue here, and that is the actual capacity, if we define "capacity," by example, as we would under the common law, as we're moving towards in both the Substitute Decisions Act and in Bill 109, the capacity to understand the issues associated with the instructions required.

In your example, which is a simple example, the question Mr Wilson raises is a good one: Would the person understand that lying in sheets that aren't changed is something about which a protest should be made, about which a demand should be made, and therefore about which action should be taken?

For the purposes of the issues associated with non-instructed advocacy, that's the wrong kind of example to use. I think important care has to be taken in terms of defining what the capacity is to instruct. We will have some people who will have far more of a communications problem than others, but they will have no problem in understanding the issues associated with what they want or need.

**Mr Owens:** In terms of the Liberal amendment, clause 15.1(1.1)(b) addresses the concerns of the groups with respect to capacity and especially in terms of the non-verbal communicators that are able, in some manner, to express their wishes. However, when you look at clause (a), I think you obviate the good work you've attempted to do in clause (b) by establishing a test that's far too high. As counsel indicated, you may end up precluding some people who are quite able to understand but who, for whatever reason, cannot meet this test.

In terms of the example that Mr Wessinger used, is there a necessity to have an appreciation for the fact that lying in faeces is not a good thing to do? I don't think so. The individual simply being able to indicate to an advocate that he or she would like these sheets changed is certainly, in my view, a good enough reason to change them. Again, in terms of the test you're trying to set, I think you've overreached yourself.

**Mr Winninger:** I tend to concur with the remarks made by Mr Owens, and I'm particularly concerned that we seem to be ignoring the point made by Ms Perlis that we could have a gap here, that we could have vulnerable people falling through the cracks because we'll set too high a standard for capacity. I note with some interest that a lot of the language in the amendment is similar to what we have in section 6 of Bill 109, capacity to consent to



treatment, which has to be a higher test. But here we need a lower test so that we don't have a gap between those who are unable to instruct an advocate, who will then not get an advocate unless there's a risk of serious harm. There are going to be a number of people caught in the cracks, who won't have uninstructed advocacy and won't have instructed advocacy. I think very deliberately the government introduced a lower threshold, a lower test, in our amendment. That's why I'm particularly concerned if we start changing that around and screening out a lot of people who could well benefit from an advocate. I hope I understood Ms Perlis's point correctly.

**Ms Carter:** To further pursue the same point, I think there's too much concentration in 15.1(1.1)(a) on the idea of giving instructions to a person who is supposed to be understanding information that's been given to them. What we're really looking at here is what that person actually wants, which is not a question of understanding what somebody else is saying; it's a question of them understanding, "I feel uncomfortable; there's something wrong here; something needs to be done," which is a far more basic thing. Maybe those wishes will be on a very simple and primary level, but they're nevertheless wishes that are coming from that person, and that is what we are looking at in connection with advocacy here.

**The Chair:** Counsel, for clarification?

2010

**Ms Perlis:** As we're not talking to a motion, I just wanted to throw in the idea that the reason understanding information is so critical to a test of capacity to make a decision about health care, or to make other important decisions such as personal care decisions or financial decisions, is because the capacity test is of the ability to make a decision. In order to make a decision, the person must be able to process the information necessary in order to make that decision, as opposed to this situation, where the person isn't making a decision. The test is their ability to tell someone what to do.

**Mr Jim Wilson:** I appreciate that, but look at the government motion in terms of wording. You not only have to be able to instruct an advocate—for which we have agreement there from counsel—but you have to be able to express the purpose. Now, if expressing a purpose for wanting the advocacy services is not implying an understanding of why, then I failed modern symbolic logic in university—and I didn't.

**Mr Owens:** Your academic record isn't at question here.

**The Chair:** Finally, Mrs Sullivan, before we move on, as these two have been stood down.

**Mrs Sullivan:** Once again, the capacity argument that has just been put forward by counsel with respect to capacity to make a decision is in fact the exact same instance. The capacity here that's required is a capacity to make the decision with respect to the instructions to the advocate. There is a decision being made by the person: That decision is on what I want, what I need, what rights I need protected and what kinds of assistance I need in expressing

those things; there are decisions being made to what limits I will allow an advocate to take my case and what limits I won't. There are decisions all the way along, and they are capacity decisions.

I understand this is being stood down for now.

**The Chair:** Then maybe we could proceed on this debate when we get the workable motion back in.

**Mrs Sullivan:** But I have a replacement motion for this section if we're ready to consider that now, or shall we stand it down until later on?

**The Chair:** As we're into the discussion, we could probably go with it right away, for the two we just stood down.

Mrs Sullivan moves that section 15.1 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Capacity to instruct

"(4) A vulnerable person is capable of instructing an advocate if the person is able to indicate a desire for advocacy services and the purpose for which he or she wishes to receive the services and is able to express, in some manner, his or her instructions or wishes."

Would you like to speak to that, Mrs Sullivan?

**Mrs Sullivan:** I think that the argumentation has been made. This is basically the combination amendment.

**Mr Malkowski:** We find that this motion is acceptable.

**The Chair:** Further discussion?

**Mr Sterling:** I'm not going to support this amendment. I understand that both the government and the Liberal Party will, but we seem to be additive in terms of the testing of a vulnerable person, and I think that's wrong.

I would have preferred something which would have said, "A vulnerable person is capable of instructing an advocate if he understands what's happening around him and there's some indication or he can give some kind of communication," period.

As we continue to add more and more things, we're talking about situations which are very, very much on the borderline and I think we're making the situation worse rather than better.

**Mrs Sullivan:** You're going back to my original motion.

**The Chair:** Further discussion? Mr Owens.

**Mr Owens:** No, I'm sorry, I missed Mr Sterling's point. I was conferring with the person from the ministry. All I understood was we're making something worse.

**Mr Jim Wilson:** I think the point of our caucus was, the simpler the better in this area in terms of access to advocacy services. If you're going to have them, people should be able to access them.

**Mr Owens:** I think that's our view as well.

**Mrs Sullivan:** My motion's a better one.

**Mr Owens:** No, I don't think it is, as a matter of fact.

**Mrs Sullivan:** It is. The PA to the Minister of Health thinks it is. My motion is a much better one.

**Mr Owens:** No, perhaps a certain section of the motion is better, but clearly the whole motion—

**Mr Jim Wilson:** Let's vote.

**Mr Owens:** This may be the time for vanity press, but—

**The Chair:** Further discussion?

**Mrs Sullivan:** The PA to the Minister of Health thinks we've got a point on this.

**The Chair:** Seeing no further comments, all those in favour of the—

**Mr Jim Wilson:** Which one are we voting on?

**The Chair:** Is this the Liberal replacement or the government replacement? The government replacement?

**Mrs Sullivan:** I moved it, so I guess it's mine.

**The Chair:** You moved it? The Liberal replacement.

**Mr Malkowski:** Excuse me. Could we just have clarification here? Maybe if we had the motion in writing, if we saw it in writing first, we'd know what we were voting on.

**Mrs Sullivan:** Let's stand it all down then until we get it in writing.

**The Chair:** It's being Xeroxed right at this moment.

**Ms Perlis:** I understand from legislative counsel that her suggestion as to the place the ultimate section should go corresponds with the place in the government motion, which is a subsection (4). If we vote on it as Mrs Sullivan's motion, then it may be located somewhere in the bill that is less appropriate. No?

**Mr Jim Wilson:** She read it in as subsection (4).

**Ms Perlis:** Oh, okay. Sorry, I missed that.

**The Chair:** The committee has it in writing now. Shall we vote at this moment?

**Mrs Sullivan:** No, we're going to stand it down.

**Mr Wessenger:** Where is it, first?

**The Chair:** It's right in front of you.

**Mrs Sullivan:** I think he's going to do some chatting with his colleagues about it.

**The Chair:** Possibly we could have a five-minute recess.

The committee recessed at 2019.

2039

**The Chair:** I call this meeting back to order.

**Mr Owens:** On a point of order, Mr Chair: Perhaps a bit of a human element. Our co-counsel, Sibylle Filion, is spending her second anniversary with us tonight, so maybe a round of applause or some form of congratulations is in order for her ability to stay with us.

**Mr Jim Wilson:** A sympathy card.

**Mr Owens:** Yes, sympathies as well.

**The Chair:** Although that isn't a valid point of order, thank you for bringing that to the committee's attention. I'm sure we all offer our congratulations.

**Mr Owens:** Thank you, Mr Chair.

**The Chair:** Any further discussion on the Liberal replacement motion on subsection 15.1(4)? Seeing no further discussion, all those in favour? Opposed?

Motion agreed to.

**The Chair:** Ms Sullivan, would you like to withdraw your motion on subsection 15.1(1.1)?

**Mrs Sullivan:** I'd like to withdraw subsection 15.1(1.1).

**The Chair:** Mr Malkowski, would you like to withdraw the original government motion on subsection 15.1(4)?

**Mr Malkowski:** Yes.

**The Chair:** Thank you. Comments on Liberal motion subsection 15.1(3)?

**Mrs Sullivan:** Mr Chairman, this amendment is put forward because of the psychology of the responsibility of the advocate. If the onus is on the advocate to take absolutely every step to ensure that the person is capable of instruction, through whatever means, it seems to me that it's a more psychologically positive demand on the advocate than the wording as it is now.

That's the reason for this being put forward. I think that the change in the onus here would create greater demands on the advocate in determining if there is any method by which a person can communicate his instructions or wishes, rather than ultimately making the assumption that there are no further steps to be taken in determining whether the person can communicate. It's put forward in that way. It seems to me a more positive and demanding role for the advocate to take every step to ensure that the vulnerable person indeed can not only participate but act on his or her own behalf.

**Mr Malkowski:** We will not be able to support this motion because the possible consequence of changing the word "incapable" to "capable" is to reverse the legal presumption that the vulnerable person in fact is capable of instructing the advocate.

**Mrs Sullivan:** I think that if we look at instances, as we will be, of vulnerable people who, by definition, have difficulty expressing their wishes, what we see is a psychology where the assumption is that the person cannot instruct because there is a difficulty in communication.

What we're saying is, "Do your best, take every effort, make every singular movement to ensure that the person is capable." Are there devices that can assist them in expressing their wishes? Is there a way or a vehicle through which the person can provide instructions, rather than saying and utilizing the popular assumption that a person who has difficulty communicating is incapable?

**Mr Sterling:** I think we're really into language here and which side of the fence we start on, and I agree with Mr Malkowski that probably we're better to start on the side of the fence that he's involved in; that is, the assumption is that the person is capable and the onus is to prove that someone is incapable.

I would like to move at this time that you perhaps put the question on this particular amendment, Mr Chairman.

**The Chair:** If we put the question now, all the other amendments will fall.

**Mr Sterling:** I'm ready to vote.



**The Chair:** Further discussion? Seeing no further discussion, all those in favour of the Liberal motion on subsection 15.1(3)? All those opposed?

Motion negatived.

**The Chair:** Okay, we go back now to the reprinted government motion on section 15.1, as amended. Discussion?

**Mr Jim Wilson:** What's "as amended"?

**The Chair:** We had the amendment with subsection 15.1(4).

**Mr Jim Wilson:** Okay. That's it?

**The Chair:** That's it. That's the amendment. We're back to the reprinted now. Seeing no discussion, all those in favour of the government motion on section 15.1? Opposed?

Carried.

**The Chair:** On the government reprint, section 15.2, any discussion? Seeing no discussion, all those in favour of the government motion on section 15.2? Opposed? Carried.

**The Chair:** Okay, the next one will be the Liberal motion, subsection 15.3(3).

**Mrs Sullivan:** This section is added simply to underline that a person who has provided instructions can change, refuse or deny those instructions on a later occasion. It seems to me that's not very clear in the bill, and while it may be implied, it's a useful addition simply to have it written down. I don't think it changes the policy. I just think it's a useful addition.

**Mr Malkowski:** The motion is certainly acceptable and we will support it. We feel the amendment simply clarifies the right of a vulnerable person or substitute to revoke or to revise instructions, so we will be supporting it.

Motion agreed to.

**The Chair:** Okay, the government reprint, section 15.3, as amended.

Carried.

2050

**The Chair:** PC motion, section 15.4. Any discussion?

**Mr Jim Wilson:** We think the motion's self-explanatory and would like to hear any concerns that other members may have.

**Mr Malkowski:** We won't be able to support the motion because there's really no need for this provision, as a person who does not accept that he or she is a vulnerable person may simply decline the advocate's services.

**Mrs Sullivan:** We'll be supporting this motion because indeed there are circumstances where, first of all, the decision is made by the advocate that the person is vulnerable or the determination of vulnerability is made by the advocate. The person, under this bill, could never be advised of that situation or circumstance.

There are all sorts of implications, including the determination of vulnerability, including access to records of that vulnerable person, with or without that person's consent, and without the consent the access to the records

is only triggered if the person has been determined to be vulnerable by the advocate. Surely a person should have the right to know that determination has been made.

**Mr Jim Wilson:** I certainly agree with the comments made by Mrs Sullivan. In addition to that, I think Mr Malkowski would like to consider that there's no clear recourse under this bill once a person has been labelled vulnerable. There's no review of that. This motion is intended to introduce some very important safeguards that I would hope, upon second reflection, the government will reconsider its position.

**Mr Sterling:** The point, I think, in addition to those raised by my colleagues, is that if we have the extreme cases, as we are talking about under section 15, the advice to the person that an advocate is acting on his or her behalf may be of interest to family members and to others, to the doctors or whoever else is involved with the care and concern of that vulnerable person. I don't think that the advocate should be acting, I guess you would say, without any kind of other person knowing that he's acting or not acting. Therefore, I guess it's a form of notice in what I am saying as well. I think it's a safer system if you have that kind of check on it.

**Mr Winninger:** I can't really agree with the comments made by opposition members with both parties on this. If we start with the premise that an advocate can be someone as simple as a friend, that it's a benign intervention—not a necessary evil like guardianship could be construed to be or treatment is perceived to be—why do you need to build in all these safeguards? All I can see is that it will make a lot of work for lawyers. I know there may be some lawyers on the opposition side who will be looking for work after the 1995 election.

**Mrs Sullivan:** Look to your own. How are jobs in London these days?

Interjections.

**Mr Winninger:** But I don't see any benefits in this section that go beyond that.

**Mr Jim Wilson:** I think also, if you follow the presentations made on two occasions by People First of Ontario, it's the label of being labelled vulnerable that can be very damaging, from its point of view. This at least gives, as I said, some review of that and then the person's aware.

Mr Malkowski's comments simply refer to the fact that you can walk away from advocacy services. You can tell the advocate to get lost, but you're still labelled. I assume advocates keep records of their visits and their determination, and this allows that to be undone if it was found to be not reasonable in the first place or if the label was found to be unjustified. I think it's just a very reasonable safeguard the government should accept.

**Mr Sterling:** When somebody is representing somebody else as a lawyer—and I have no desire to get back to a profession which I left five elections ago—

**Interjection:** Hear, hear.

**Mr Sterling:** But if that ever should happen, I would imagine that whenever a client came through the door, I would get a retainer from that client.



With regard to the representation that's made by an advocate under section 15, there is nothing there which essentially retains the services of an advocate. We have a person who is vulnerable, who can't communicate, who may or may not understand what's going on around him. I would think that some method of formalizing the representation of that person's interests would be best in terms of people around or concerned with the rights of that individual knowing that this advocate was there and that the formalization of that is very, very healthy, both for the commission and for the individual. I think that sort of expresses the view of the amendment.

**Mrs Sullivan:** I really want to underline that the labelling of "vulnerable" triggers the right of other people, third parties, to take all sorts of action with respect to that person, including access to records. Because the advocate is doing the categorization, if a person whom an advocate sees as having difficulty in expressing his or her wishes and so on, and therefore the advocate categorizes that person as vulnerable and is able to take action, and the person himself or herself doesn't see himself or herself that way, there is no route for that person under which he or she can say, "I don't want that in my file, period."

**Mr Jim Wilson:** It's also, I think, a useful mechanism for the commission itself. If a vulnerable person wants to challenge the labelling, as this motion would allow, it helps the commission to review the decision made by its own advocate, and I don't see any problem with that either. It's internal and simply is checks and balances.

**Ms Carter:** It seems to me an advocate is entitled to have access to the person's records without his or her consent only if he or she is incapable of giving or refusing consent. Otherwise, presumably, they would have to give it.

Another point is that I think we're getting into rather strange realms with this business of labelling because, after all, what we started out with is a situation where some people are vulnerable because they have been given a label and people therefore refuse to treat them as though they are the capable human beings that they may in fact be. So I think to start to talking about "vulnerable" as a label is getting rather ridiculous. It's just saying you can't help people because you might then be leading to the inference that they need help.

**Mr Jim Wilson:** Just briefly in response to that, I did include in my remarks the fact that People First felt very strongly on labelling as vulnerable individuals. I'm not an expert on it, but I take their word for the fact that people do get labelled and that at times that can cause concern and problems.

**Ms Carter:** Perhaps they need an advocate to protect themselves from it.

2100

**Mrs Sullivan:** I'd rather use an ad hominem argument, and I understand that's the weakest one, but I'll tell you, my mother is a stroke patient. She would fit into the definition of vulnerable as it was included in this act. She would be outraged if an advocate labelled her as vulnerable because she fit that definition and was able, under the

section with respect to uninstructed advocacy, to take steps in relationship to obtaining clinical records and other records because the advocate simply made that decision. This route of appeal is a protection for her.

**Mr Sterling:** We always assume under this act that the advocate and the client, the vulnerable person, are acting in concert. That may not necessarily be so. I would hope that in 99% or 95% or just about all the cases that would be so, but in the cases where it is not happening, then that vulnerable person may want, for instance, to retrieve the records the advocate has gained access to on his or her behalf.

How does the vulnerable person exercise that right? I would submit that this kind of appeal mechanism allows the vulnerable person to confront the advocate in front of the commission and say, "I don't want this person out there claiming he's representing me any more, and I want all the records which he or she has obtained on my behalf." We're not talking of all the cases—very few of the cases—but when you're creating the powers that you can give or an advocate can get under this act, then you must put in the complementary safeguards, and this is the safeguard which we consider as appropriate in this act.

**Mr Malkowski:** I appreciate the concerns that have been raised by both the Liberal and PC members, but I'd like to emphasize that the advocate is only going to act on instruction from the individual, or without instruction if there's risk of serious harm. It's also important to note that People First also said it wants advocates to be available to them. They made that clear.

**Mr Owens:** In terms of the concerns expressed by members opposite, I can't see anywhere in the act thus far where the advocate has the ability to (a) label a person as being vulnerable and then (b) move off into whichever direction he or she wishes, without any kind of consultation with the person he or she is allegedly advocating on behalf of. I'm not sure that addresses the point.

In terms of Mr Wilson's comments with respect to People First, I think he's clearly mixing apples and oranges and trying to come to some kind of conclusion on this amendment. Yes, People First clearly resist being labelled, but in terms of the issue the PC caucus is trying to address, I think he's trying to hit a mark that just isn't there.

**Mrs Sullivan:** I think that the point that Mr Owens made with respect to the advocate not undertaking any activity without the involvement of the vulnerable person is quite incorrect. The issue in many cases here that would be in there relates to non-instructed advocacy.

**Mr Winninger:** I keep coming back to section 15.1(1), which says, "An advocate who is providing advocacy services to a person shall not do anything that is inconsistent with the person's instructions or wishes."

Surely you can't get a more mandatory statement than that. So it's incumbent on the advocate to follow the wishes and instructions of the vulnerable person, and I think you're setting up a conflict here which just doesn't exist in actual fact.

**Mr Sterling:** The problem with the system as envisaged as far as I can see is there's no point of engagement



or disengagement with the vulnerable person. There's no point which says, "You're now on board; you're now my client," or there's no point in the system which says, "You are no longer my client." How does the vulnerable person or people close to the vulnerable person, or both, determine whether the advocate is off seeking information about him, advocating services which he may or may not want? How does he know when the engagement starts and when the engagement ends?

**Mr Jim Wilson:** Mr Winninger makes a good point, but the next subsection deals with non-instructed advocacy. That's what we're trying to get at. Just take a moment to read that quickly.

**Mr Owens:** Just in terms of the comments from Mr Sterling, clearly it's not the advocate who decides whether his or her services are no longer required. The amendments we have passed thus far clearly make it a client-driven process, as opposed to the advocate imposing his or her services.

**Mrs Sullivan:** Unless a client can't drive.

**Mr Winninger:** I seem to be responding interminably to Mr Wilson's points, but subsection (2) only comes into play if there is a risk of serious harm. So that's going to essentially limit the number of cases where subsection (2) comes in. Furthermore, subsection (3) says subsection (2) does not apply unless the advocate has taken all reasonable steps to seek instruction.

**Mr Jim Wilson:** That's silly. Mr Chairman, on a point of order there.

**Mr Winninger:** It's a conjunctive—"and."

**Mr Jim Wilson:** But clause (2)(a) says if "the vulnerable person is incapable of instructing an advocate."

**Mr Winninger:** And "there's a risk of serious harm."

**Mr Jim Wilson:** Sometimes that becomes rather a subjective decision an advocate may make, that a person may disagree with, hence we're trying to introduce some safeguards.

**Mr Winninger:** We accepted safeguards like "reasonable risk." We took the word "reasonable."

**Mr Jim Wilson:** You were on a roll, and I'd encourage you to continue along that line.

**Mrs Sullivan:** I want to go back to the question of clause (b) as a protection, the risk of serious harm, once again for the person who does not want to be classified as vulnerable and therefore have all the other functions of the act. I agree with Mr Sterling that this will happen in few cases, but the question is who determines, who makes the judgement about whether there is a risk of harm.

In presentations with respect to Bill 109, we heard many examples of instances where, by example, an Alzheimer patient may have complained to other people, and that would lead an advocate to believe there are reasonable grounds to suspect serious harm. The advocate may well take steps in association with that instance when in fact the person is not vulnerable. He will now be in a file and will now have that file existing.

I just don't understand why the government is so adamant about not including this when it's just a minimal protection

for a person about whom a judgement has been made, a determination has been made, and action has been taken which, in the case of uninstructed advocacy, is highly intrusive.

**The Chair:** Counsel, for clarification?

**Ms Perlis:** I'm just going to point out that there is a check on the non-instructed advocacy situation—that is, the duty imposed on the advocate to report non-instructed advocacy situations to the office of the public guardian and trustee under section 30. Mr Fram isn't here to speak to the interaction between this bill and that bill, but in any situation in which an advocate has offered or provided services to someone in a non-instructed situation, he or she is mandated to report that to the office of the public guardian and trustee. That is a check and balance.

2110

**Mrs Sullivan:** That's exactly the point. It's another file. Now it's gone. It's not only with the commission, it's with the PGT. The person doesn't want it to be anywhere.

**Mr Jim Wilson:** The point is, what if someone, as a vulnerable person, gets him or herself into this advocacy system and then suddenly decides: "This isn't really going the way I thought it would go. It's maybe causing more harm to my daily life than I thought. There are these files being created on me"? How do they get themselves out of that? As Mr Malkowski said, they can tell the advocate to leave, but meanwhile there's a paper trail and a trail of interviews and contacts.

Wouldn't it be nice if the person could go to the commission and say, "Look, upon second thought, I might have been in a delirious state or something for a while, but I'm fine now and I'd really like to sort of undo what's happened over the past month"? That's part of the point here.

**The Chair:** Further discussion? Mr Winninger?

**Mr Winninger:** I'll not make a contribution at this point.

**Mrs Sullivan:** He was going to tell us he was going to support this vote.

**Mr Winninger:** It wasn't met with great enthusiasm.

**The Chair:** Seeing no further discussion, all those in favour of the PC motion on section 15.4?

**Mrs Sullivan:** Recorded vote.

The committee divided on Mr Jim Wilson's motion, which was negated on the following vote:

**Ayes—5**

Brown, Eddy, Sterling, Sullivan, Wilson (Simcoe West).

**Nays—6**

Carter, Malkowski, Morrow, Owens, Wessinger, Winninger.

Section 16:

**The Chair:** The government reprint on subsection 16(2): comments? Seeing no comments, all those in favour of the government motion, as reprinted, of subsection 16(2)? Opposed? Carried.



Section 17:

**The Chair:** We'll go to the Liberal motion, alternate 1, on section 17.

**Mrs Sullivan:** I think it's self-evident, Mr Chairman. I'd like this section of the bill struck out.

**Mr Jim Wilson:** I'd just note that we'll be supporting the Liberal motion and that it was identical to a motion introduced by our party, which we withdrew because of the redundancy in the two motions.

**Mr Malkowski:** We'll not be supporting that motion because it's important that we retain the advocate's right of entry.

**Mr Sterling:** Can I ask how many other delegated officials have this right of entry to these kinds of premises?

**Mr Winner:** I'm glad you asked that question. The Ontario Law Reform Commission did a report on powers of entry, if I can just quote from it, because I think it addresses your question:

"In studying the legislative framework respecting powers of entry, it is clear that these powers have been conferred frequently. Express authority to enter land or premises, without a warrant, is granted in 223 public statutes, 61 private statutes, 86 regulations, and numerous bylaws."

I can give you a breakdown too on private dwellings versus non-private dwellings, a breakdown with or without warrants, but the evidence is really quite compelling. If you'd like me to table with the committee part or all of this research that Susan Swift did at my request, I can do that. It might save time now.

**Mr Sterling:** How many of those were agricultural acts?

**Mr Jim Wilson:** Or environmental acts?

**Mr Sterling:** It was quite a common process within the agricultural community too.

**Mr Winner:** I've got a breakdown categorized by purpose. Out of 300 public statutes, health accounted for 55, general administration accounted for 115, planning and environment accounted for 39, safety accounted for 48, revenue 18, quasi-criminal 14 and human rights 11.

In addition, you have specific sections from various statutes that confer powers of entry, and in many cases the criteria are more lax than here. For example, a fish inspector in BC—this isn't an Ontario act but a British Columbia act—can come in and inspect fishing apparatus, and I suppose fish, in your own home without a warrant. So if we can allow a fishing inspector into a home, certainly where there may be a vulnerable person seeking the intervention of an advocate, that would be a stronger case for entry.

As I say, I have a lot of information here and much of it is not as stringent as the test we set out. The test is not dissimilar—counsel can correct me if I'm wrong—to that under the Child and Family Services Act where you have a child in need of protection.

**Mr Sterling:** How many of these acts concern people who are in a direct, adversarial position to the person who is controlling the premises?

**Mr Winner:** These statutes apply to private residences regardless of whether the owner happens to be in

an adversarial situation or not. Warrants are issued to enter premises. Take the child and family services worker. She often may be required to go into a residence of parents who strongly and vehemently object to her entry. You can call that an adversarial situation.

Here I think we have a vulnerable person who may wish to seek intervention or see an advocate, and there's a check on that, because if the vulnerable person decides he or she doesn't want to see the advocate, then the advocate leaves.

**Mrs Sullivan:** I think this issue is greater as an issue than what in fact is the current law. There have been recent court cases which are charter cases, and the laws have not been changed since those court cases have been put forward. They relate to the right to enter for purposes of search. The right to entry of the advocate in many cases will be for the purposes of perhaps searching for the vulnerable person, for evidence of abuse and generally observing the premises. In those instances, a search would be carried out within the meaning of the charter.

2120

We feel very strongly that Judge Dickson, who made the recent decisions which were affecting the statutes Mr Winner has referred to, indicated that the purpose of the search and seizure, chapter 8, is "to protect individuals from unjustified intrusions upon their privacy." He stated that this purpose required prevention of such searches before they happen, not justifying them after the fact; thus, only a system of prior authorization could fulfil that purpose and therefore, the necessity for a search warrant would follow.

The only exception under common law would be when a consensual search was permitted; in other words, if the person admitted the advocate who knocked on the door and requested entry, then the normal protections against intrusions would therefore not apply. But in that case there is a different right to entry accorded to the advocate and different consequences would follow.

We feel that this is a charter issue, and that the warrant from the justice of the peace is a necessary part of the protection of people themselves in terms of their right to privacy and in fact a requirement of the Charter of Rights and Freedoms in Canada.

**Mr Malkowski:** We can also look at constitutional law opinions on that. I'll refer to our legal counsel to discuss that issue.

**Ms Perlis:** There are a couple of issues I want to speak to; one is to go back to the question that was posed to Mr Winner about the number of statutes that have entry provisions that don't consist of agricultural matters and so on. I thought perhaps I'd cite a few for the benefit of the committee.

Entry powers are given to investigators under the Human Rights Code, to advisory officers under the Mental Health Act, to inspectors under the Nursing Homes Act, to the Ombudsman and officers under that act, to inspectors under the Public Hospitals Act, and to persons, including medical officers of health, under the Health Protection and



Promotion Act, and of course the Child and Family Services Act provisions referred to by Mr Winninger.

On the subject of what the law is, I feel it's too difficult and complex to state baldly that there is no actual law I can state outright in this context, but I do feel it's important that the committee know that the current provisions as reflected in the reprinted bill are felt by the constitutional law people at the Ministry of the Attorney General to be able to withstand a charter challenge. They fall within the recent case law and the charter. We actually have three opinions and have consulted extensively with the staff at the Ministry of the Attorney General. It isn't just one opinion and our sections. In fact, our amendments reflect the very details of the constitutional opinions we have received.

**Mr Winninger:** With respect to some of the case law cited by my learned friend Ms Sullivan, there can be a distinction drawn between the right to search and seizure, for example, and what's being contemplated here, which is the mere right to meet with a vulnerable person. I would also say that there may be a finding that a right of a private owner is violated, but it's demonstrably justifiable in a free and democratic society under section 1 of the charter, the saving section.

I would just add that I think it's noteworthy that the report of the Ontario Law Reform Commission said: "In relation to the decision to make an entry, it will be noted that only approximately one fifth of all the powers conferred by the public statutes of Ontario limit the circumstances in which an entry may be made by requiring something more than a simple, discretionary decision on the part of the public official to whom the power has been given. Relatively few statutes, for example, require a warrant or prior judicial authorization in the form of a court order."

So I think this statute has safeguards built into it that are absent from four fifths of the statutes of Ontario, and I can't understand why it's being subjected to criticism.

**Mrs Sullivan:** With reference to the very issue Mr Winninger has raised, in the Supreme Court decision on this issue—I'm reading from a briefing note with respect to it, but it includes quotes from that decision—the court held:

"A search and seizure is reasonable only if authorized by a statute, and if the following three conditions are required by the authorizing statute." The first is a requirement of a warrant or other authorization to be obtained in advance of the search; a requirement that the warrant be issued by a person who is "capable of acting judicially," ie, impartial, and a requirement that the warrant be issued only after it has been established that there are reasonable and probable grounds to believe that an offence is being committed, ie, a sworn showing of probable cause.

**Mr Winninger:** We are not talking about search and seizure.

**Mrs Sullivan:** We are talking about comparable instances, where the advocate would be making searches (a) for the person; (b) for evidence of abuse, and (c) for a

review of the circumstances within those premises or facilities.

**Mr Sterling:** It's difficult to compare the right the government is asking for to enter private residences and private facilities in this legislation. I believe the government in the past has been far, far too liberal in permitting delegated officials this right, but many of the instances we have heard talked about are either minor in nature in terms of their impact on the private lives of individuals or they have, in a lot of cases, commercial values or commercial interests at heart, so you have the entrance into a commercial establishment for purposes of obtaining books or obtaining samples etc.

When you look at the Human Rights Commission and bodies like that, you look at bodies which have a right to maintain a level playing field for the people who are in front of them and are therefore, in a way—I guess you would almost call them a court. So I think it's difficult to compare the purpose of this legislation with something like the Human Rights Commission. The Human Rights Commission is there to make decisions after hearing both sides of the case. Therefore, you would assume that whatever rights they have would be dealt with with the sensitivity of that at hand.

This commission is unabashedly for one segment of society. What you're saying is that, in the name of that one part of society, you're going to give them tremendous entry powers into private property, and we think the checks and balances you require here are not adequate.

**Mr Winninger:** When the advocate tries to gain entry to a private entrance between the hours of 8 am and 8 pm and the owner says, "No, you're not getting into my house," then the advocate has to seek a warrant. Surely that's the check and balance. Then a justice of the peace has to be convinced that a warrant should be issued. What better check can there be?

**Mr Sterling:** Well, up to this time, if that particular situation had arisen, an advocate might go to the police and say, "I think somebody is being abused there." What would the police have to do in order to gain entrance to that residence? They'd have to get a warrant. So we don't understand the reluctance on the part of the government to require that.

2130

**Mr Winninger:** To require what?

**Mr Sterling:** A warrant.

**Mr Winninger:** A warrant is required if the private owner says the advocate cannot enter.

**Mr Sterling:** For a private residence.

**Mr Winninger:** Yes, right.

**Mr Sterling:** But not for a private room in a nursing home.

**Mr Winninger:** I think in the nursing home the earlier provision kicks in where you can gain—maybe we can hear from counsel on this—entry to the communal facility but not to the private rooms.

**Mr Malkowski:** Just to respond to some of the concerns and debate that has gone on, we have heard from



constitutional lawyers. They've given us advice, and they have in fact considered the case you have cited. Referring to their opinion, they have said that in fact the current amendment as it stands would withstand a charter challenge. Therefore, I feel we are ready to vote. I certainly am ready to vote on this issue.

**The Chair:** Further discussion? Seeing no further discussion on the Liberal motion alternate 1, section 17, all those in favour? Opposed?

Motion negatived.

**The Chair:** Liberal motion alternate 2, subsection 17(2).

**Mrs Sullivan:** This amendment would ensure that the right of the advocate to enter a facility without a warrant would, as it does with a controlled-access residence, apply only to the common areas of that facility including entry-way, hallways, elevators and stairs, and that the advocate could not enter the private dwelling unit or room of the person without the person's consent or without a search warrant in the facility as well as the controlled-access residence.

It seems to me that the same courtesies that would apply to a room, for example, in a nursing home should apply to a room in a hospital. The addition of "facility or" is an important amendment to ensure that advocates, without consent or without warrants, do not have any further right to invade in what is an intensely private situation in a hospital, the specific room, without the concurrence or other protections provided in other sections of the act.

**Mr Winninger:** I find that a little onerous. I'm just speaking from my own experience where I would go to a hospital room of a patient as a rights adviser paid for by the legal aid plan, and in some cases the patient wanted to see me and in other cases the patient said, "Get lost," and I got lost.

Why would you want to control access between an advocate and someone who may or may not want to see him or her in that way? Why would you want to extend that to an uncontrolled access situation where anyone, theoretically, could go up and visit a patient during visiting hours? I just don't follow your thinking there.

**Mrs Sullivan:** There is no indication in this bill that the advocate is limited to visiting a patient in a hospital during visiting hours. The advocate can go in at any time, with or without the patient's invitation, in no matter what state of dress or undress the patient may be, in the course of the presentation or involvement in treatment, while the person is having discussions with other health care practitioners.

This is ludicrous. You simply cannot have a wide-open option to allow someone who has never met that person to move without invitation and without other authorization into the private room of a hospital. You don't even want your brothers and sisters and mother and father doing that, or husband or wife.

Why should an advocate have any additional rights to intrude in that way on a person? It's nonsense not to include "facility" in that section. Let the advocate go to the common area and the advocate can let people know that he or she is there. Give them the right to go to the common

area, but don't give them the right to intrude into the private room where care is being given and where the person is sick or he wouldn't be there in the first place.

**Mr Malkowski:** The government will not support this motion. It's important to emphasize that respect is one of the first purposes of the whole Advocacy Act. The advocate in fact may need to meet with a resident or patient who is confined to a room, or where it is the most private place to meet. If a vulnerable person, however, wants the advocate to leave, the advocate must do so.

In an institution the advocate would in fact be required to do this. Entrance into a hospital room is allowed for cleaning staff, for people who are providing food to that individual and a variety of other people. I think we've discussed this to the point that we should vote on it.

**Mr Jim Wilson:** I was wondering if we could seek unanimous consent to continue with Bill 74 tomorrow afternoon, agreement to proceed with Bill 108 in the morning while Mr Sterling is with us, because members realize that Mr Sterling is unable to be here tomorrow afternoon and we have some significant amendments to Bill 108, and to adjourn this debate for the evening. Do we have unanimous consent to reopen Bill 74 tomorrow? It is getting very difficult to concentrate and this is an important section. I think we all want the evening to think about it.

**The Chair:** Do we have unanimous consent to return to Bill 74 tomorrow afternoon?

**Mr Malkowski:** Actually, I'd like to recess and caucus for, say, five minutes before we respond.

**The Chair:** The committee will recess for five minutes.

The committee recessed at 2140.

2148

**The Chair:** I call this meeting back to order. Once again I'll ask, do we have unanimous consent to return to Bill 74 tomorrow afternoon?

**Interjections:** No.

**Mr Malkowski:** Because of the time allocations and restrictions we have, we feel that we should continue with discussing the amendments through this evening.

**The Chair:** We don't have unanimous consent. Once again, on the Liberal alternate 2 motion, Ms Sullivan, the subject is subsection 17(2). Further discussion?

**Mrs Sullivan:** I really take exception to the fact that the parliamentary assistant to the Minister of Citizenship has indicated that he sees the right of entry of an advocate into a hospital room as being akin to being a person employed by the hospital to do certain work for the hospital, including housekeeping duties or delivery duties.

Those people who are employed by the hospital are not allowed to enter the room in certain circumstances. There is no limit on an advocate—recall that in most cases the advocate will be unknown to the person in that hospital room—to limit that person's time of entry. The advocate now, under the first section of this section, has to merely present his identification and indicate that he is there and has the authority to be there and has the authority to enter that patient's room.



A physician could be administering an enema; the advocate can come in. There could be medical treatment occurring; the advocate could go in. There could be discussions with family or friends; the advocate could go in. There is nothing that stops an advocate from going in to that private room, without the consent of the person. The consent of the person is a negative consent. The person must say, "You have to get out of here," not, "Please come in."

I think this is an outrageous intrusion on personal privacy. The access to the common areas of the hospital is appropriate. The access, without question, to the individual room where the patient is located is absolutely, totally, 100% inappropriate. The hospital representatives who were here before us objected with enormous strength and passion to this section of the bill. The medical representatives who appeared before us objected to this section of the bill. If there were patients' rights associations before us—and there weren't, unfortunately—they too would have objected to this section of the bill.

I cannot imagine a patient who would welcome, within the circumstances of being in a hospital setting and given the way most patients are housed in a hospital, not in private rooms but in semi-private or quadruple-patient rooms, that without any limitation, an advocate can enter that room without the specific invitation of the person who is there. If there is indeed question with respect to harm that will come to that person, there is access and protection for that person through obtaining a search warrant in a latter section.

I think this is really an offensive section. I can't imagine why the government will not move on this. It's extraordinarily intrusive.

**Mr Malkowski:** To respond to Ms Sullivan's concerns, the important point to remember, though, is that personal privacy will always be respected first and foremost.

**Mrs Sullivan:** Oh, baloney.

**Mr Malkowski:** I think we should now move to a vote.

**Ms Carter:** Just quickly, I'd like to point out that in section 17(1) it does say that the advocate is entitled to enter at any time that is reasonable in the circumstances. It's not a carte blanche just to go barging in at any moment. I think the likelihood of an advocate trying to do it when the person is undergoing treatment or in the middle of the night or something like that is remote. I'd also just like to add that there seems to be a complete absence, in the case that's been presented to us, of any concern about this person whose rights are presumably being infringed upon in some way, or else the question of having an advocate wouldn't have arisen.

**Mrs Sullivan:** We don't know if the person's rights are being infringed upon. We know that a judgement has been made by an advocate that a person who is under medical care in a hospital is vulnerable, and that determination of vulnerability, the way this act is now worded, gives the advocate the right to enter the private room or the semi-private room in a hospital.

Could I ask the parliamentary assistant to the Minister of Health whether in fact, under the Public Hospitals Act—I know he's familiar with it—the hospitals themselves are required to make rules with respect to restriction of access to individual rooms, and if, under the Public Hospitals Act and the regulations, the inclusion of facilities in this section is therefore almost a requirement. I believe that is the case.

**Mr Wessenger:** I'm not in a position to give you that answer tonight, Ms Sullivan. If you wish, we can try to provide it for you.

**Mrs Sullivan:** Mr Chairman, I'd like to stand this section down.

**The Chair:** Do we have unanimous consent to stand this section down?

**Interjections:** No.

**The Chair:** We don't have unanimous consent.

**Mr Malkowski:** No, we don't. I think we should go with the vote.

**Mrs Sullivan:** I would like to ask the government then to explain its policy intention with respect to the insistence that an advocate should have a right to enter a room in a hospital where a patient is receiving medical treatment, as is allowed in this section of the bill. Why do they want that in? What is the policy intention that they're attempting to accomplish here? Who was consulted?

**Ms Valentine:** Simply from a policy standpoint, there are thousands of people who are hospitalized in nursing homes and in a variety of other settings in Ontario. Ontario has one of the highest rates of institutionalization of elderly people in the world. Over 50% of people in provincial psychiatric hospitals have been there for over five years. There are numerous people who are in situations they are not conveniently able to leave, or if at all, able to leave their bed, let alone their room, without great difficulty, perhaps with somebody lifting them out into a chair for a while.

I think Mrs Carter pointed out the phrase "at any time that is reasonable in the circumstances," combined with the primary premises of the bill: respect for disabled persons, the dignity of disabled persons etc. I think it really all needs to be read in context. There is certainly not the intent to intrude upon the privacy of anyone, but the intent is to be able to provide advocacy to people where they are, wherever they need it.

**Mrs Sullivan:** The policy adviser has talked about people who are living on a permanent or semipermanent basis in many different kinds of institutions, including nursing homes. Our understanding is that a nursing home would be considered a controlled-access residence.

This bill provides the right of an advocate to enter the controlled-access residence, only the common areas of that residence, and does not allow the advocate to enter the private dwelling unit, which may be a room, which may be an apartment, depending on the nature of the home, without the consent of the person, or if there is authorization under subsequent sections 18 and 19, one of them being with a warrant.

under subsequent sections 18 and 19, one of them being with a warrant.

We are asking for that same protection for the person who is in a hospital that is offered to a person who is in a controlled-access residence. We do not see the difference in the treatment of people who are in a facility vis-à-vis those who are in a controlled-access residence. We want the same protections: that there should be consent and that other protections that are provided by latter sections of the act will also apply to facilities as they are described under this act.

**The Chair:** Response from counsel.

**Ms Perlis:** "Facility" is defined in this act in section 2 as, "A facility governed or funded under an act mentioned in the schedule." The schedule in fact lists the Nursing Homes Act and the Homes for the Aged and Rest Homes Act. So in fact nursing homes, whether funded municipally and not for profit or regulated under the Nursing Homes Act, would be facilities for the purposes of these sections, not controlled-access residences.

**Mrs Sullivan:** That makes it even worse. I'm going to ask again that this area be stood down. That makes it even worse. In fact, there may well be a charter argument in this section specifically.

**The Chair:** Do we have unanimous consent to stand this section down?

**Interjections:** No.

**Mr Malkowski:** No, we don't. I think we are ready to vote. I'm certainly ready to vote on this issue.

**The Chair:** I'm sure we're all ready to vote, but is there further discussion?

**Mrs Sullivan:** I suppose we can talk about this for an awfully long time. We've had, as you know, interventions before the committee in relationship to this section that described the very nature and importance of this kind of amendment being put forward.

We've had representation from nursing homes, from doctors, from nurses and from hospitals saying that the kind of intrusion that's envisaged in this section of the act is unwarranted, unhelpful, unnecessary and indeed could itself be problematic in terms of the other right that has to be balanced, and that's the right to appropriate health care, and an additional right, the right to privacy.

I still haven't heard what I asked for from the government earlier, which is the public policy purpose of this section of the act. I think we're entitled to that. When enormous personal rights are being challenged and interfered with by the inclusion of this section of the act, I would like to know what the public policy purpose of its inclusion is.

**The Chair:** Perhaps in the best interests of all committee members we'll recess for 10 minutes.

The committee recessed at 2202.

2229

**The Chair:** I call this meeting back to order. Mrs Sullivan still has the floor.

**Mrs Sullivan:** Thank you. I know there are other members of the government who want to speak to my particular amendment. I am, as you are clear, adamant about the principles and the practicality included in the amendment I put forward and, as I've indicated, I'd like once again to hear what the public policy purpose is for not including facility in that section.

**Mr Morrow:** I haven't talked much today so I'll keep it as brief as I can. Mrs Sullivan, you're right, there is an awful lot to discuss on this. With your indulgence I would ask for your consent that we return to this tomorrow afternoon at 2 o'clock and that we adjourn the committee.

**The Chair:** Do we have unanimous consent? Agreed. This committee stands adjourned until 10 o'clock tomorrow morning.

The committee adjourned at 2230.



## CONTENTS

Tuesday 1 September 1992

Advocacy Act, 1992 . . . . . J-305

### STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

- \***Chair / Président:** Cooper, Mike (Kitchener-Wilmot ND)
- \***Vice-Chair / Vice-Président:** Morrow, Mark (Wentworth East/-Est ND)  
Akande, Zanana L. (St Andrew-St Patrick ND)
- \*Carter, Jenny (Peterborough ND)  
Chiarelli, Robert (Ottawa West/-Ouest L)  
Curling, Alvin (Scarborough North/-Nord L)  
Harnick, Charles (Willowdale PC)  
Mahoney, Steven W. (Mississauga West/-Ouest L)
- \*Malkowski, Gary (York East/-Est ND)  
Runciman, Robert W. (Leeds-Grenville PC)
- \*Wessinger, Paul (Simcoe Centre ND)
- \*Winner, David (London South/-Sud ND)

#### **Substitutions / Membres remplaçants:**

- \*Brown, Michael A. (Algoma-Manitoulin L) for Mr Mahoney
- \*Eddy, Ron (Brant-Haldimand L) for Mr Curling
- \*Owens, Stephen (Scarborough Centre ND) for Ms Akande
- \*Sterling, Norman W. (Carleton PC) for Mr Harnick
- \*Sullivan, Barbara (Halton Centre L) for Mr Chiarelli
- \*Wilson, Jim (Simcoe West/-Ouest PC) for Mr Runciman

\*In attendance / présents

#### **Also taking part / Autres participants et participantes:**

Auksi, Jutta, senior consultant, policy development branch, Ministry of Health  
McKague, Carla, counsel, Office for Disability Issues, Ministry of Citizenship  
Perlis, Linda, policy analyst, Office for Disability Issues, Ministry of Citizenship  
Malkowski, Gary, parliamentary assistant to the Minister of Citizenship  
Valentine, Mary Beth, senior policy and program adviser, Office for Disability Issues, Ministry of Citizenship

**Clerk / Greffière:** Freedman, Lisa

#### **Staff / Personnel:**

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J-18

J-18

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## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Wednesday 2 September 1992

### Standing committee on administration of justice

Substitute Decisions Act, 1992

Advocacy Act, 1992

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Mercredi 2 septembre 1992

### Comité permanent de l'administration de la justice

Loi de 1992 sur la prise de  
décisions au nom d'autrui

Loi de 1992 sur l'intervention



Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
Greffière : Lisa Freedman





### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

### **Index inquiries**

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La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Wednesday 2 September 1992

The committee met at 1046 in committee room 1.

### SUBSTITUTE DECISIONS ACT, 1992 LOI DE 1992 SUR LA PRISE DE DÉCISIONS AU NOM D'AUTRUI

Consideration of Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne.

**The Chair (Mr Mike Cooper):** I would like to call this meeting of the standing committee on administration of justice to order. This morning we'll be starting our consideration of clause-by-clause on Bill 108. Our first amendment is in the government reprint, subsection 1(1).

Possibly we could get some clarification here. Was it the committee's understanding that it would be one five-minute opening statement at the very beginning of the clause-by-clause consideration or at the beginning of each of the bills?

**Mrs Barbara Sullivan (Halton Centre):** It appears that we've had different understandings. My understanding was that we would speak to all four bills, but I think my colleague in the third party, who has a particular interest in Bill 108, had a different understanding and expected that there would be an individual statement with respect to each of the bills. I think it might be useful if we had that statement, and to hear from the government as well.

**The Chair:** It seems the government side concurs with that.

**Mr David Winninger (London South):** I'd like to say a few words on behalf of the Attorney General in connection with Bill 108. I'd like, first of all, to thank the staff of this committee for their excellent work thus far in bringing these proceedings to this point. I'd also like to thank the minister's political staff, who have assisted greatly.

I'd like to thank in particular Steve Fram, who's sitting to my left today, the architect, if I may call him that, of the Substitute Decisions Act, who's been a great support all through these proceedings and, many of you may have noticed, has attended very consistently and regularly.

I'd also like to thank my executive assistants, Lynne Jeffrey and Lois Pineau, who has temporarily abandoned her career as a philosophy professor to assist in these proceedings.

I'd also like to thank the civil servants within the Ministry of the Attorney General for their able assistance. I'd also like to thank the opposition members for sharpening our wits over the last couple of days, and certainly late into last night.

This Bill 108 I think effects a balance between those who would seek to enhance the autonomy and independence of incapable and vulnerable people while at the same time assuring those who are incapable of making decisions for themselves, even partially, that there is a substitute decision-maker available to make decisions that are appropriate with the expressed wishes of the individual or vulnerable person, and in the absence of expressed wishes, certainly in accordance with the best interests of that person.

We've listened very carefully to the very strong presentations by members of the public and community organizations and various professional groups throughout. They've been extremely well presented. The fact that the government responded with 199 amendments is certainly testimony to the value of the contribution of the public, and at the same time the opposition members, at least in the case of Bill 74, have put forward a number of very useful and helpful amendments. Again, where we saw merit in the amendments, we've certainly been willing to vote in favour of them, because we want the best possible legislation we can achieve.

In her opening remarks, Ms Sullivan did voice a number of concerns. I suggest that these were voiced, perhaps, in a tone of studied hysteria. There was reference to "panic-stricken." Ms Sullivan quoted Mr Sterling in the phrase "jackboot tactics," when our party has always been known for wearing Hush Puppies. I found that rather odd.

**Mrs Sullivan:** I wouldn't push the foot image.

**Mr Winninger:** Certainly not into anyone's mouth. I suggest that our government has reached a level of perfection here that's laudable, considering the challenges of introducing what is clearly state-of-the-art legislation, that other provinces haven't yet achieved but I know are quite interested in.

I note tangentially that a week ago I received a call from a fairly senior social worker in Saskatchewan whom I met a few years ago in connection with a child representation case. He was interested in getting phone numbers for the official guardian's office for the child representation office, the child advocacy office here in Ontario, because they don't have such institutions. They've set up an advisory committee to try to bring in what we've clearly enjoyed for a number of years. He was quite impressed at the strides we were taking with this advocacy legislation and certainly seemed to find that it was worthy of emulation in Saskatchewan.

What I'd call the studied hysteria has to be countered here today in my opening. Ms Sullivan referred to burgeoning bureaucracy at enormous public cost, families which will be pitted in an adversarial position with advocates, and the injured not receiving access to timely treatment. I feel that our amendments have gone a long way towards addressing all of those concerns, and I invite the



members opposite to try to avoid this kind of scorched-earth approach to our legislation and raising public hysteria at the risk of, I think, promulgating insecurity among members of the public.

I would also suggest to Mr Sterling, who indicated in his opening remarks that our advocacy legislation does not provide vulnerable people one more bed, one more meal or one more treatment, that certainly if you provide beds, meals and treatment, it's important that there be someone who can be what's called a friend to vulnerable people and assist them in achieving proper nutrition and proper accommodation and allowing them to have some input into treatment decisions that are made. I don't think you can put a price on human dignity, and certainly our legislation is designed to accord a larger measure of dignity to vulnerable people than they've enjoyed hitherto.

In reference specifically to the piece of legislation I'm steering through, I would indicate at this point that the Attorney General remains actively interested in these proceedings and is continually briefed on what is said and done in these proceedings, and to suggest that the Attorney General or other ministers are not interested in this legislation and in these proceedings is clearly incorrect. Many, many meetings have taken place to ensure that these pieces of legislation are well integrated and that concerns have been addressed.

Particularly with Bill 108—I'm getting some signals about the time—we did in the reprinted version introduce some substantive amendments, three in particular, to address concerns that were expressed.

One was to allow what is called a pre-validated power of attorney, popularly known as the Ulysses clauses, to enable people to be treated during what might be psychotic interludes. They have, I guess, signed an instrument that's been validated in advance that would allow them to be treated, notwithstanding certain objections during psychotic episodes that they may regret later because they wouldn't have the treatment they needed.

Secondly, we've lowered the threshold for competency to appoint a power of attorney for personal care and, thirdly, we've allowed a power of attorney to have some effect if the grantor doesn't object prior to validation, because that would allow an attorney to make certain important decisions and take certain steps prior to validation.

The amendments we've introduced at this stage, following the very valuable hearings in August, are largely of a housekeeping nature. However, there will be one amendment of a substantive nature which we may seek to introduce following further discussion.

We've just now received the helpful suggestions of the Liberal and Tory caucuses in terms of amendments to the bill, and I look forward to discussing them further during the course of this debate.

**The Chair:** Thank you, Mr Winninger. Ms Sullivan, would you like to make an opening statement?

**Mrs Sullivan:** I'm going to be very brief. I think we will find that this bill will in fact be easier to deal with than Bill 74. Certainly there are fewer amendments coming for-

ward, and those amendments will be more of a technical nature.

The work that has been done on substitute decision-making has now been through three governments, and with fairly extensive early work under all three. We certainly appreciate some of the major amendments which were put forward in the government's first interim round. We felt those amendments relating to the expedited power of attorney were particularly useful.

I'd also like to commend ministry staff for their cooperation in providing advice to us and explanations of sections where there are some arcane properties included in the bill and making them perhaps seem less arcane, although we still do have amendments in some of those areas.

I also want to pay tribute to Mr Sterling—which I did, I think, as we were going through hearings—who brought forward, as a private member, living wills legislation that may have provided an impetus for some of the work that's here. I think that kind of participation from a private member is really key to the shaping of legislation and enhances the role of a legislator.

I wish that as much care and as much consideration had been put into Bill 74 as has been put into this bill. I think we will find that we'll be able to proceed without the acrimony that is attached to Bill 74. While we still have some concerns and hope we will have further explanations about who would qualify, by example, to be an assessor and what his or her role and training are, and we will have questions as we proceed through the bill, there will be a far different atmosphere with this bill than there has been with Bill 74.

1100

**Mr Norman W. Sterling (Carleton):** I'd like to start out by thanking Mrs Sullivan for her kind comments.

We've had a lot of people in Ontario and in Canada who've been interested in the subject. One of the people I'd like to recognize is Marilynne Seguin of the Dying with Dignity group, who has, through her own efforts, educated much of the Canadian public as to the whole issue of facing that terminal decision and trying to maintain the dignity of the individual as he or she approaches that final day. She has worked very hard with a whole number of volunteers in Dying with Dignity, and I think helped bring this issue to the fore.

I've had some experience in relation to the whole idea of empowerment. My interest in this area goes back to the early 1980s when I served in the cabinet of William Davis and brought forward a bill to create a durable power of attorney or a continuing power of attorney for property, past the point of capacity to incapacity. Prior to that time, the only way a person could have his business affairs taken care of was to have a committee appointed by a court or for the public trustee to take over the affairs of an individual. It was a costly procedure for private citizens to make.

I felt at that time we could move the law along and provide that a person sitting down with his friends and advisers could provide for contingencies in the future which he may not foresee so that his personal assets and



property could be taken care of by a friend or family member after he had lost the ability to take care of them himself. I worked very closely with the Alzheimer society in bringing forward that piece of legislation on behalf of the Attorney General and carried it through this Legislature in 1982 or 1983, I believe.

Today we are dealing with another matter, power of attorney for personal care, and it is somewhat groundbreaking. Well, it is ground-breaking for this province, because we have never had a piece of legislation in place which permits an individual to appoint another friend to maintain his wishes when he is no longer capable of speaking for himself, to put those wishes in place when he is most vulnerable, usually at a later stage in life, but it can occur during all of our life.

I first introduced legislation in this area some three years ago, before the last election, dealing with both power of attorney for personal care and with living wills, which we will be dealing with in Bill 109. I continue to be concerned about making these kinds of instruments, these kinds of opportunities which Ontario citizens will have after Bills 108 and 109 become law. I continue to be concerned about keeping it as simple as possible. In doing that, I know that you have to take some risks, that there could be some kind of abuse down the road, and our caucus will focus on making this process as simple as possible.

I would have liked both the power of attorney for personal care and living wills to be embodied in one piece of legislation as separate and apart from other issues, but I'm quite willing to work with Bills 108 and 109 and hope that by the development of appropriate forums, through education, the public will be able to understand the concepts and will be able to execute these kinds of documents. I hope they will therefore be empowered to control their lives much longer and maintain the dignity they want to have during all their lives.

I'm encouraged in terms of the government dealing with the issue of guardianship. I hope that through Bill 108 parents of schizophrenic patients will have the ability to make certain that their schizophrenic family members will be able to receive appropriate treatment so that they can be useful citizens of the province and can in fact get the treatment I'm convinced they need.

I want to say that we have continued to deal with this piece of legislation in as constructive a manner as possible. We don't anticipate that the hearings on Bill 108 will take all that long. We are going to focus most of our concern with regard to the issues of making these documents—I'm talking about the powers of attorney—as accessible to as many people in the province as possible.

**The Chair:** I thank all parties for your opening comments. We'll now proceed to clause-by-clause.

The first one is in the government reprint, subsection 1(1). Any comments? Seeing no comments, all those in favour? Carried.

The next one is in the government reprint, subsection 1(2). Any comments? Seeing no comments, carried.

Government reprint, section 5? Carried.

Government reprint, subsection 7(1)? Carried.

Next is PC motion, subsection 7(2).

Mr Sterling moves that subsection 7(2) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended and the following added:

"7(2) ...or provide a gratuitous benefit directly or indirectly to a witness to the continuing power of attorney."

**Mr Sterling:** Mr Chairman, with your indulgence, I would like to also move my amendment, which I believe is next in order, on section 10 because the two are interrelated.

**The Chair:** Is there unanimous consent to introduce both motions? Agreed.

Mr Sterling moves that section 10 of the bill, as reprinted to show the amendments proposed by the Attorney General, be struck out and the following substituted:

"10(1) A continuing power of attorney shall be executed in the presence of two witnesses in the manner described in subsection (3).

"(2) The following persons shall not be witnesses:

"1. Any person who might receive a benefit from the attorney.

"2. A person whose property is under guardianship or who has a guardian of the person.

"3. A person who is less than 18 years old.

"(3) Each witness shall, if the witness has no reason to believe that the grantor is incapable of giving a power of attorney, sign the power of attorney as witness.

"(4) A continuing power of attorney that does not comply with subsections (1) to (3) is not effective, but the court may, on any person's application, declare the continuing power of attorney to be effective if the court is satisfied that it is in the interests of the grantor or his dependants to do so."

1110

**Mr Sterling:** These two clauses deal with the problem of who can or cannot witness a power of attorney dealing with property. I believe the qualifications of the witnesses should be different when dealing with power of attorney for personal care, because there are different interests associated with dealing with property and dealing with health treatment.

Basically, I think that when you come down to the bottom line, you don't want anybody to be a witness to the document where a person is giving someone else the right to transact business on his or her behalf if he or she is away from the jurisdiction or he or she is incapable of making decisions.

The people who witness it should not in any way directly benefit from the attorney who has received that power to act on his or her behalf. Therefore, instead of trying to delineate who should or should not sign that power of attorney then, I have simply made it one test, or essentially one test, and that is, if you witness a power of attorney, the attorney acting under that cannot go back to the witnesses and say, "You are going to receive a gratuitous benefit as a result of my power." I guess it's as simple as that.

I have made a few other exclusions. I don't think a witness to a power of attorney should be a minor. I think it's not an onerous requirement to make somebody 18. Also,



I put in the exclusion regarding guardianship. It's a little different approach than has been put in by the government, but I'm going to listen to any objections that people might have to this kind of approach.

**Mr Winninger:** I'm a little concerned with the amendments put forward by Mr Sterling to subsection 7(2) and section 10. It's true that in section 10 we preclude a person related to the grantor or attorney by blood, adoption or marriage, basically a family member, from acting as a witness. However, we do have the saving section for non-compliance under subsection (5), which means that you could have a family member witnessing a power of attorney; you could have a family member going to court and asking that the power of attorney be effective notwithstanding a breach of one of the earlier provisions.

I note that you have a saving provision as well. But the concern here is under, first of all, subsection 7(2), if, let's say, a son or daughter of the donor of the power of attorney were a witness to the power of attorney and, notwithstanding that, the court approved it as effective, later on in that child's life the donor may wish to confer a benefit upon the child, and it would seem to me and Mr Fram that your amendment would preclude that eventuality. I'll ask Mr Fram if he has anything to add.

**Mr Steve Fram:** There's a lot that's very appealing to Mr Sterling's motion. It in fact follows the kind of provision that has been a requirement of wills, that a witness to a will cannot receive a benefit under the will. The central difference between it and a will is that you know when you make a will who the beneficiaries are, or the classes of beneficiaries, so you can say, "No, don't sign." The problem with the amendment that's proposed is that anybody might receive a benefit.

I was thinking about this on my way to work this morning, because I was privy to conversations with Mr Sterling yesterday about the proposed amendment. If I were making out a power of attorney for property, for example, the most likely person I would call on to witness that would be my next-door neighbour, Murray Sedgewick. Murray Sedgewick would be a person whom, if he got into difficulty, I would like my wife to benefit. They have been good friends for a long time. And I could express that intention.

As a lawyer, if someone asked me and Murray was there, knowing that, I would have to say, "No, Murray, you can't be a witness." Indeed any one of my family or my wife's family is now precluded, because all the people I like can't be witnesses. I don't know when they're going to fall into difficulty and I would want my attorney to take care of my friends and family in their difficulty if there's money to do it, without having to go to court to get approval.

It's that total lack of predictability that makes it a concern for me. I see that for some people the provisions of the government bill will have difficulties. Subsections 10(3), 10(4) and 10(5) are raised again not only in Mr Sterling's motion but in the proposed Liberal motion to change it.

It's a question of, how far do you go trying to cut off, and it's something the committee I chaired for six years struggled with for a long time, but reasonable people can disagree with the conclusions it reached. The conclusions they reached are here. The issue is, how far do you cut out all of those who are close to the person because you're worried that the witness will be in collusion with the attorney to defraud the grantor?

The second problem with Mr Sterling's proposed change to section 10 is that it makes two sets of witnessing requirements for powers of attorney. Most people will do them together. They will do a power of attorney for property and they will do a power for attorney for personal care, and to have two sets of different witnesses to essentially the same kind of proposition—that is, "I'm giving to you the authority to make decisions if I become incapable"—seems to add a level of difficulty to the documentation that we want to keep most simple and direct for people to work with.

1120

**Mrs Sullivan:** I think it's appropriate to speak to this now without reading our motion in because I think we've been considering to some extent what a witness should be doing and who should be a witness and we have reached different conclusions. The conclusion our party has reached is that simplicity is the best approach; that the witness is there to ensure that the person purported to be making the power of attorney is making the power of attorney. The role there is as a witness, not as a party, to the activities that are taking place within the discussions relating to the power or the content of that power. That is something for the person who is giving the power of attorney to another individual.

So our conclusion with respect to the witnesses is quite different from the third party's conclusions. Ours are to keep it simple and flexible. We have to understand, as well, that in certain circumstances there will be only certain people available to the person without quite considerable expense. By example, I would think that Mr Sterling's motion—there may be a legal surround to the word "benefit" that I don't know—would exclude people who are employees of a nursing home when the person in the nursing home, who may be capable of giving a power, would have no other recourse but those people as witnesses, without calling in and paying for a lawyer or making some other interventions.

Does a person employed in a nursing home receive a benefit or could there be seen to be a conflict under Mr Sterling's motion? I don't know what the legal ramifications of that word are, but my preference would be to keep it simple.

**Mr Sterling:** I thought it was simple. If there was any chance of your receiving a benefit, don't witness it. That's basically the rule. The only other rule you really need to know is that the witness has to be 18 years or more. Instead of having categories there, you have the one rule.

I think, in fairness, Mr Fram's second argument that the consistency between dealing with the witness requirements for a power of attorney for property and a power of



attorney for personal care be the same, is a somewhat compelling argument. His first argument, with regard to the fact about Mr Sedgewick who lives next door, I think, is—I wouldn't, when talking about Mr Fram, talk about a specious argument, but I would say that there are, what is it, three billion other people besides Mr Sedgewick and his wife who might sign a power of attorney? Therefore, I don't think the public out there in general are going to have a great problem finding two witnesses who, at some time in the future, might benefit in a gratuitous way—in other words, a gift—from the power of attorney you are appointing to take care of your property.

The most compelling argument is if you can line up a reasonable set of witness requirements for both the personal care attorney and the one dealing with property. Unfortunately, I'm not sure you can, because the considerations of protecting the grantor are quite different in dealing with the two kinds of issues.

**Mr Winninger:** I'm reasonably confident that all of the safeguards that need to be in here are already in section 10. I would also suggest that Mr Sedgewick has probably already received a gratuitous benefit in being for ever immortalized in the annals of Hansard.

**Mr Paul Wessenger (Simcoe Centre):** I'd just like to add that I think subsection 10(2) is restrictive enough and perhaps even more restrictive than it ought to be. So for that reason I can't really support Mr Sterling's amendment.

**Mr Sterling:** Mine is surely less restrictive than subsection 10(2) by a long, long shot, because if a brother or a son wants to sign as a witness, then he knows that he's excluded. You don't restrict anybody from being a witness if he or she is 18 years or more, but you pay the penalty, and as long as you do it with your eyes open, so be it. It's not restrictive of anybody in the world. So you can't say that my amendment in any way restricts anybody, save and except it restricts the person who has the power to bestow a benefit on a person who's been a witness, much like a will, as you said.

**Mr Wessenger:** My concern relates to the—

[Failure of sound system]

**The Chair:** Excuse me, that wasn't picked up. We'll have a one-minute recess.

The committee recessed at 1126.

1127

**The Chair:** I call this meeting back to order.

**Mr Wessenger:** My main concern relates to the situation of a prohibited person witnessing and then being deprived of a benefit, as raised initially by Mr Winninger. I think that's my main concern. I'd prefer to have the flexibility there than the restriction.

**Mr Sterling:** I don't think we should prolong the discussion on this. I'm the proposer of the motion and I feel that there's some flexibility on the part of the government in terms of removing some of the witness requirements on the other part, so I'm ready to vote if the rest of the committee is.

**The Chair:** Seeing no further discussion on the PC motion on subsection 7(2), all those in favour? Opposed?

Motion negatived.

**The Chair:** On the PC motion on section 10, all those in favour?

**Mr Sterling:** I withdraw that motion, Mr Chairman, because it wouldn't make sense without subsection 7(2).

**The Chair:** Withdrawn? Thank you very much.

Okay, back to the government reprint on subsections 7(3.1) and (3.2). Any comments? Mr Winninger.

**Mr Winninger:** I was expecting the Liberals, who put forward the motion, to speak in support of it.

**The Chair:** No. This is the government reprint.

**Mr Winninger:** Sorry. Government reprint? Okay.

**The Chair:** Subsections 7(3.1) and (3.2).

**Mr Winninger:** I assume that's going to carry. Is it carried?

**The Chair:** No, we haven't voted yet. Carried? Carried.

Back to the government reprint, subsection 10(1). Discussion?

**Mr Wessenger:** Could I just make a point? If an amendment is carried with respect to subsection 10(2), there could be an effect on subsection 10(1). Am I correct there? Perhaps we should stand down subsection 10(1) until we deal with subsection 10(2).

**Mr Winninger:** We have a Liberal amendment.

**The Chair:** Do we have unanimous consent to stand down subsection 10(1)? Agreed.

Okay, the Liberal motion on subsection 10(2).

Mrs Sullivan moves that paragraphs 3 to 7 of subsection 10(2) of the bill, as reprinted to show the amendments proposed by the Attorney General, be struck out.

**Mrs Sullivan:** I've pretty much spoken to this motion in discussing the issue with respect to Mr Sterling's amendment. I should also tell you, depending on how the discussion goes here, I also have a replacement motion, which would only take out paragraphs 3, 4 and 5, which is, as I judge the nature of the discussion, the appropriate way to go. If we can have a nod, then what I would do is withdraw the motion just read into the record, read a replacement motion into the record, and then we can take that as the motion that I want to put forward.

**Mr Winninger:** May I respond? Basically, since the deletion of paragraphs 3, 4 and 5 would not be inconsistent with the rest of the legislation or government policy, we won't be objecting to that, but as you acknowledged, we do need to retain paragraphs 6 and 7.

**Mr Sterling:** I think when we're looking at this, we should look at it not only in terms of a power of attorney dealing with property but as a power of attorney for personal care, so that we have two consistent requirements. As I said, Mr Fram's argument that we have consistency between the two is somewhat compelling.

I have a little problem with removing paragraph 3, quite frankly. I agree with paragraphs 4 and 5 being removed and I think removing paragraphs 4 and 5 is the biggest problem you face in a practical sense. But in dealing with



personal care, I'm not certain the grantor, who is treating someone as a child of his family, should have that person, the child, signing the power of attorney. I think the connection is just too close and it invites too much mischief in certain circumstances. That's where I would draw the line, but I'm quite willing to listen to argument from other members of the committee. I would like paragraphs 4 and 5 to be removed but have some difficulty with paragraph 3.

**Mr Wessinger:** I'd just like to say that with respect in particular to paragraph 4, from a practical point of view, having practised law and having done many wills in hospital settings, I think it would be extremely difficult going to the hospital if you couldn't use one of its employees to witness a power of attorney, especially when you need two witnesses. From a practical point of view, it creates a lot of difficulties, so I would certainly like to see paragraph 4 deleted. I don't particularly have any problem with paragraph 5, so I would tend to agree with Mr Sterling that deleting paragraphs 4 and 5 would make sense.

**Mrs Sullivan:** I think I understand the arguments that have been placed about involvement of families as witnesses. The question is, in terms of this issue, what is the person doing? The person is witnessing a document, the contents of which that person may or may not have any knowledge. The assurance of that witness is that the person who is the grantor and the person who becomes the attorney are participating as parties. It seems to me that the concerns about the obligation of the family in the participation on the personal care issues relate to the content of that power rather than the witnessing of the power and what in fact is included at the instruction of the person who is granting the power of attorney.

In the situations we're looking at, in terms of whether it's a granting of a power of attorney for property or a granting of a power of attorney for personal care, simplicity is the issue. The ease of formalizing the document, I think, is going to be important because there will be stresses and discussion and emphasis placed on the content of the power of attorney, in which the witness has not a part. I would prefer, as I've indicated, to remove 3, 4 and 5 and just keep it as simple as possible.

**Mr Sterling:** I think if you're going to go for a general rule, the rule should be in terms of people understanding it. Your family can't witness this. That's what's going to be practised out there. That's the way I think it should be. Your family and everybody will say—if it's a blood relative or it's an adopted child or it's whatever—they won't sign as witnesses. I think that's more of a simple rule than saying that the spouse or partner can't sign but the child can sign, or whatever. I think the common definition in layman's language will become that the family can't be witness to this. That will be the bottom line.

I agree that 4 is the key one that has to come out; 5 is such a small part of it. I would suggest you take 5 out, because it might be done unwittingly or people wouldn't even be aware that they were party to the same suit that was going on. You could have a class action that was—and I'm not sure of the click-in time. Is it as of the time when you sign as witness, or is it when you bestow the benefit?

You can get into other issues which I don't think are really relevant to most of the cases.

I again say that 4 and 5 are the ones that I would prefer out, and I would ask Ms Sullivan to consider that. If not, I'm willing to put in an amendment for just 4 and 5 after that amendment.

**Mr Winninger:** Mr Chair, could we call for a five-minute recess?

**The Chair:** This committee will stand recessed for five minutes.

The committee recessed at 1138.

1149

**The Chair:** I call this meeting back to order. Do we have unanimous consent to stand this down until we redraft it? Agreed.

On the government reprint subsection 10(1), should we also stand that down until the redraft? Agreed.

We will move to the PC motion on subsection 10(3).

Mr Sterling moves that subsection 10(3) of the bill, as reprinted to show the amendments proposed by the Attorney General, be deleted.

**Mr Sterling:** To date, with regard to powers of attorney dealing with property, there's no such requirement of witnesses at present to determine the grantor's capacity or incapacity to sign the power of attorney. My wish is to try to encourage people to make these kinds of documents. If we throw too much of an onerous responsibility on witnesses to make a determination as to the ability of the grantor or the person signing the power of attorney, we're going to get people who are reluctant to act as witnesses. If you want the Sedgwicks next door to act as witnesses, then this is an unreasonable thing to ask of people who are signing something and not getting any kind of compensation for it.

**Mr Winninger:** I am pleased to say we favour that amendment as well for two basic reasons: One is that, as presently worded, the section confers a rather onerous responsibility on a witness and, second, that the witness may lack the required expertise to assess the capacity of the grantor of the power of attorney so that—

Interjection.

**Mr Winninger:** Mr Fram advises that a consequential amendment to subsection 10(4) would have to flow from Mr Sterling's motion, to strike out the content of subsection 10(4) after the word "witness." You may note that the Liberal motion is along those lines.

**Mr Stephen Owens (Scarborough Centre):** I wholeheartedly agree with Mr Winninger's comments and certainly look forward to supporting Mr Sterling's motion.

**Mrs Sullivan:** I certainly support this motion. However, I also have an amendment which would strike both subsection 10(3) and subsection 10(4), which would take out any assessment requirement on behalf of the witnesses.

I see counsel is indicating that the only other area which would be problematic is where it says that the witness should sign a prescribed form. I wonder if he would advise us if that would not be simply part of the power of attorney and if the powers to prescribe forms under the regulations

wouldn't include the witness portion actually on the power, rather than on a separate form.

In my view, if we take out subsection 10(3), we should take out subsection 10(4) as well; prescribed forms are allowed in other places in the legislation.

**Mr Wessinger:** I would support the deletion of (3), but I do think it's necessary that there be some form of provision that the witness make a statement that he or she believes the person signing the power of attorney is capable. In other words, you clearly don't want the situation occurring where someone witnesses a signature where he or she knows the person is incapable. I think we need some protection against that aspect.

**Mr Winner:** I appreciate Mr Wessinger's comments and Ms Sullivan's comments. However, as I said, if we are prepared to delete subsection (3) and the last two lines of subsection (4), we do need to maintain the first four lines of subsection (4), simply because it envisages a situation where a witness may have reason to believe that the grantor is incapable of giving a continuing power of attorney. In that instance then, that person cannot sign on as a witness. So we need the first four lines in there.

As to Mr Wessinger's comments about "make a written statement in the prescribed form," again if there were a written statement in the prescribed form, then the witness would be commenting on the grantor's capacity, and that's the situation we want to obviate here. A simple affidavit of execution, which has always been acceptable in the past, would suffice, and if anyone wanted to challenge the capacity of the grantor under the circumstances, it could be challenged in the court.

I would just conclude by saying that we are prepared to delete subsection (3) and the last two lines of subsection (4), and if that were acceptable, perhaps we could ask legislative counsel to draft an amendment.

**The Chair:** Thank you. That's been done for you.

**Mrs Sullivan:** I think that's an appropriate way to go, and although I haven't introduced them, I will withdraw my amendments.

**Mr Sterling:** I guess we will need a vote on my amendment.

**The Chair:** Yes, we will.

**Mr Sterling:** I'm prepared to vote on that now, Mr Chairman.

**The Chair:** No further discussion? All those in favour of the PC motion on subsection 10(3)? Opposed?

Motion agreed to.

**Mr Sterling:** Mr Chairman, I have a motion which has been drafted by legislative counsel to deal with subsection 10(4), so I'll move that.

**The Chair:** Mr Sterling moves that subsection 10(4) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by striking out "and at the same time make a written statement in the prescribed form."

**Mr Winner:** That's certainly an acceptable amendment. We'd be prepared to vote in favour of it.

Motion agreed to.

**The Chair:** Mrs Sullivan, you're withdrawing your motion before it's introduced?

**Mrs Sullivan:** My motion will be withdrawn.

**The Chair:** Thank you. Back to the government re-print on 10(1).

**Mr Winner:** Can I comment on that?

**The Chair:** Yes, Mr Winner.

**Mr Winner:** Just at a quick glance, I think subsection 10(1) would have to be amended to delete reference to subsection (3), and that would do it.

**Mr Sterling:** Don't they do that? The clerk can clarify this. You don't need an amendment in order to do that. That is done, I think, just as a matter of administration. I don't think you have to worry about numbers or whatever, because it just happens.

**Mr Winner:** At the same time, while we're discussing the amendment, subsection 1(5), Mr Fram points out, would have to be amended as well.

**Mr Sterling:** I think the numbering is taken care of regardless. I mean, that's all you are worried about.

**The Chair:** Because of the time, maybe we could deal with this tomorrow when we get back to Bill 108 and go to recess for lunch. This committee stands recessed until 2 pm this afternoon.

The committee recessed at 1200.



## AFTERNOON SITTING

The committee resumed at 1420.

## ADVOCACY ACT, 1992

## LOI DE 1992 SUR L'INTERVENTION

Consideration of Bill 74, An Act respecting the Provision of Advocacy Services to Vulnerable Persons / Loi concernant la prestation de services d'intervention en faveur des personnes vulnérables.

**The Chair:** I call this committee back to order. Mr Malkowski would like to make a statement first.

**Mr Gary Malkowski (York East):** I'd like to open by responding to Barbara Sullivan's concerns from yesterday related to entrance to hospital facilities without a warrant. Further to the discussion of last night, I just would like to clarify that issue in relation to Bill 74.

Bill 74, the Advocacy Act, gives advocates authorized under the act the power to enter facilities such as hospitals and nursing homes without a warrant for the purpose of providing advocacy services to the vulnerable and disabled residents of these institutions.

Advocates must present identification on request and they may enter at times "reasonable in the circumstances." Advocates are permitted to enter patients' rooms as well as common areas. Advocates are entitled to meet with vulnerable persons without interference and in private.

One of the chief purposes of the act is to provide advocates to assist vulnerable persons in speaking up to care providers, voicing their own wishes and concerns and exercising their rights. If advocates are not able to freely enter facilities, severely disabled, immobile, restrained or confined residents, who most need advocacy services, will effectively be denied access to advocates in practice.

The government is not interested in setting up an advocacy system which provides advocates only to people who are physically mobile or to persons who are able to attend public meetings or hear about these services. This government is determined to provide universal access to advocates regardless of disability.

The powers of entry to facilities under Bill 74 are neither unique nor extraordinary statutory powers in Ontario.

Inspectors, medical officers of health and public health inspectors are all authorized under the Health Protection and Promotion Act to enter "any premises" "at reasonable times" for the purposes of that act.

Inspectors under the Homes for the Aged and Rest Homes Act are entitled to inspect homes "at all reasonable times."

Advisory officers appointed under subsection 5(9) of the Mental Health Act, including psychiatric patient advocates, may enter any psychiatric facility "at any time." They are given specific statutory authority to interview patients and inquire into matters concerning patient care.

Pursuant to the regulations made under the Homes for Special Care Act, inspectors can enter homes for special care, including nursing homes and licensed residential homes, "at any reasonable time."

The Developmental Services Act authorizes officers appointed by the Ministry of Community and Social Services to enter facilities "at any time" and includes an express reference to the right of the officer to interview residents.

In all of these statutes, public officials who have direct contact with vulnerable patients and residents have virtually absolute discretion over the circumstances of entry.

Entry to facilities by advocates under Bill 74 will be exercised in accordance with the overriding principles of the act—ie, to contribute to the empowerment of vulnerable persons and to promote respect for their rights, freedoms, autonomy and dignity. To suggest otherwise is to imply that advocates will not have basic respect for vulnerable people.

**The Chair:** Thank you. Just a reminder to the committee members that we are on the Liberal motion, alternate 2, on subsection 17(2).

**Mrs Sullivan:** The explanation which has been given by Mr Malkowski is precisely the reason, in fact, that we see grave concerns in these areas. The illustrations he's used from personnel, by example, under the Public Health Act, under the Regulated Health Professions Act and under the homes act demand that the people who are entering those places are not entering those places without specific expertise, either in medical care issues or in the management of health care facilities of their nature.

In fact, I have discussed at some length with people who are involved in the implementation as public health officers the way they are enabled to enter a facility and what their practice is, and indeed their practice is never to enter a private room without the consent of the individual. Their practice is never to interfere and intervene in a situation where there is concern about that access.

The act also includes other checks and other balances against undue interference with the privacy of the patient concerned. This bill has no checks and no balances on the advocate.

We understand the role of the advocate. Everybody in the room understands the role of the advocate. I point out to you, however, that the advocate is the person who determines if a person is vulnerable, who determines, on reasonable grounds or suspicion, that a person needs the services of the advocate, who determines what time is reasonable. It's the advocate who determines whether it's a reasonable time, no one else, and it's the advocate who determines what steps are going to be taken with that person.

I cannot recall any other piece of legislation that has such limited checks and balances in terms of rights on invasion of privacy, and I continue to believe that this is a Charter of Rights issue. This is well beyond the needs that are evident and well beyond what the practice should be.

The advocates will not necessarily be trained in every particular health care issue—when we're talking about health care institutions, by example—that is being dealt with within that institution, nor with every disease or illness a



person has who is resident in a nursing home or in another long-term care facility which would be affected by this act.

If an advocate were to judge, on the basis of lack of information, that restraint, by example, was an abuse, and if that restraint were occurring at 10 o'clock at night, the advocate, under this bill, would have full and effective freedom to enter a private room and to demand, on behalf of that patient, with or without the patient's consent, that action be taken, because the advocate can assume as well that the patient is incapable of instructing the advocate and therefore can speak in the place of the patient, using the vogue term "standing in the shoes" of that patient.

There are, as you know, certain rational and needed times when restraint is not only a viable but necessary portion of health care. That's been recognized in the common law. It's been a matter of considered discussion over the years, and indeed in the Consent to Treatment Act and in fact in this bill the restraint provisions are also recognized. That an advocate would have adequate medical training to make a judgement on the single visit or a visit that occurs at any time on a suspicion or rumour which may come to him or her, although that rumour could be interpreted as reasonable grounds, is absolutely incomprehensible.

1430

We know, because we've had some indication, that the advocate's training courses are not going to include enough education to ensure that advocates are going to be educated in the health care problems of all of the people who will be vulnerable in any situation. The treatment methods could well be understood if there isn't that adequate training and expertise in that area. That's one matter of concern. The other, of course, is the singular invasion of privacy in situations which are extraordinarily intrusive.

I want to suggest to you further that the provision of this section would not only enable an advocate to enter a private room in a hospital, but because it is so broad and so unlimited, the advocate would also have the right to enter an examination room in a hospital, even while an examination is being conducted. The advocate would have the right to enter a labour delivery room while delivery was ongoing. There is no check and no balance in that situation. The advocate would have the right and the power to enter an intensive care unit in a hospital. There is no check and no balance on that.

This is ludicrous, insisting that the same responsibilities of the advocate to have access to the common areas of a facility as are provided for in the common areas of a controlled-access residence is appropriate. The advocate who then presents his or her identification at the nursing station can be advised, by example, if the patient is in the middle of an examination or if there are physicians and other people involved at that moment in the treatment of that person. It is not only a matter of preserving the privacy of the patient, it is also a matter of simple courtesy.

While I understand all of the rationale for the involvement of an advocate with a vulnerable person and I accept that, there is absolutely no way I will not continue talking on this section until I have some understanding and some commitment from the government that it will accept this

amendment. We are prepared to go till 3 o'clock this morning on this amendment if that's the will.

**The Chair:** Further discussion?

**Mr Jim Wilson (Simcoe West):** The 3 am stuff really doesn't worry me too much.

**Mr Owens:** Since you won't be here.

**Mr Jim Wilson:** Every once in a while, common sense must prevail and one must know when—

**Mr Owens:** Let me know when it does.

**Mr Jim Wilson:** When one gets the sense that the committee's bogged down, you can stop hitting your head against the wall I suppose. Certainly I would agree, on behalf of my caucus, with much if not all of what Mrs Sullivan has said. Members know that we introduced the exact amendment and withdrew it because it was the same as the Liberals' amendment.

We just very strongly feel that there should be clear and consistent wording and application of this bill in terms of the advocate's right of entry into both controlled-access residences and facilities. I think the government has to keep in mind that under both situations, these facilities or residences are actually the vulnerable person's home while they are in either the facilities or the controlled-access residences. Subsequently, it only makes sense to us—and I haven't been able to really figure out what the problem is from the government's point of view—to have equal application under the law to both of these types of facilities and residences.

I think it defies common sense to do otherwise, and again I would welcome the government's reasoning of why it opposes this because I don't think it's been clearly delineated by Mr Malkowski or any other member. I don't think it is that we're not listening; I just think the government may have missed the point here. It makes abundant sense to have equal application here.

**Mr Malkowski:** There are certainly many issues that I could respond to but I'll choose one specifically. Ms Sullivan refers to restraint. In fact advocates are asked to become involved. If they were to become involved in inappropriate or illegal use of restraint and seclusion, in fact it is illegal to confine people or force confinement in that way. There have been issues of this brought to the attention of the media.

Last year an elderly patient died because of inappropriate use of the very issue of restraint. The government is interested in providing advocacy services to such people who are not in a position themselves to phone for an advocate to get that help. The government is interested in making sure that such provision is available for these people.

**Mrs Sullivan:** I think this, once again, goes to the very issue. We will have a person who is an advocate who will be untrained in the medical decisions that are being made in relationship to a portion of the treatment or care with respect to a person. That advocate, untrained in those issues, can, because he or she sees a person who is in restraint, make determinations that the person is being abused, any time of the day or night, in any situation, without any check or balance, and can do so by invading



the private housing of the person at the time, the private home, whether it's in a nursing home, whether it's in a hospital, whether it's in a rest or retirement home, whether it's in many other institutions, including major numbers of institutions that are Ministry of Community and Social Services facilities.

Everyone who is in a facility that is a hospital, that is a nursing home, that is a long-term care residence, that is an institution, a group home, by example, under Comsoc, is not a vulnerable person, is not a person who should also be invaded by an advocate because of information that has come his way, which may or may not be correct, without a check and a balance.

There is an assumption that all medical care people are evil, all hospitals and institutions are evil, and therefore the rights of a third party to enter not only where the patient is or where the person is but to hold the assumption that there is something incorrect happening to that patient, rights that are greater—and I will repeat it, rights that are greater—than those accorded to our police forces in this province, are provided to that advocate to intervene.

1440

Common-area access is what we're requesting. Why would there be any difference in common-area access to controlled-access premises than there would be to a facility? I think it would be very interesting to hear from the parliamentary assistant to the Minister of Health on how the minister and that ministry see this kind of unilateral right of people who are in fact untrained medically to have access to any area of any hospital, because there is no limitation to any area where a patient is, perhaps even in the course of treatment, without any check or balance.

I'm going to ask specifically for the participation of the parliamentary assistant to the Minister of Health in this discussion. This is absolutely unprecedented in terms of access.

The examples that Mr Malkowski used yesterday about cleaning staff are specious. We're talking about people who are entering a private room for a purpose. They are searching either for the vulnerable person or for abuses that are happening to the vulnerable person, or they will be making judgements about what is occurring in that room or on that premise. There is absolutely no check on their access.

I believe, frankly, that this is a charter case. But in terms of the practical management of hospitals, the Minister of Health, as the person who is responsible for reporting to the Legislature and implementing the Public Hospitals Act, by example, and the Nursing Homes Act, by another example, must have some comment on this.

**Mr Malkowski:** I just want to stress in response that the advocate can really only bring to attention the concerns of those individuals. They can only bring these issues to the attention of those people in authority and they are also only exercising the same rights that all of us have for people who cannot speak for themselves. The advocate cannot remove the restraints or undertake any similar action. There's no assumption that anyone is evil, and the advocate

is not making that kind of assumption. They are simply identifying a difficulty and informing the authorities of that.

**Mr Wessenger:** I don't intend to engage extensively in this debate other than to say that if Ms Sullivan's amendment were to pass, I would suggest that the act would be of no particular use to a major portion of the vulnerable persons and we might as well junk the whole act. That's the first thing I would say if it were to pass. I wouldn't see much effectiveness of the act in dealing with protecting the rights of vulnerable people.

Secondly, this concept of "uncontrolled access": I strongly disagree that the act provides "uncontrolled." There are some words that are very limiting in this act and those are the right to enter "at any time that is reasonable in the circumstances." I think that's quite a restrictive right, and certainly any institution would say it's inappropriate to enter at various times that would, for instance, be contrary to health, contrary to particular privacy situations. The particular instances raised by Ms Sullivan, in my opinion, would not be reasonable in the circumstances.

**Mrs Sullivan:** Could I ask the parliamentary assistant if he would comment then on the proposition included in the act so that anyone who hinders or obstructs an advocate who is entering that private room is subject to legal repercussions? A hospital now can insist, by example, that only one person at a time who is a member of the patient's family can enter the intensive care unit. There would be no such restriction allowable for an advocate under this act.

**Mr Wessenger:** I'd have to ask for legal opinion on this question. I think we'll ask legal counsel to take the circumstances of a hospital employee telling an advocate, "You can't go into the ICU because of the unstable condition of the patient." I would like to ask legal counsel's opinion on that.

**Ms Linda Perlis:** I would just like to point out that this section does require that the entry be reasonable in the circumstances. I don't think entering an ICU in the middle of urgent treatment would be reasonable in the circumstances.

**Mrs Sullivan:** The reasonableness is established by the advocate. There is no right of the institution itself to establish what is reasonable. In fact, the obligation on the facility is to ensure that the advocate enters, because if the advocate is obstructed or hindered from entering, the facility is then liable and can be prosecuted for not allowing the entry.

**Mr Wessenger:** I don't want to get into legal arguments here, but I would suggest that if the institution gave a reasonable reason for not admitting the advocate, there would be no infringement of the act at all.

**Mrs Sullivan:** Then let's have the reasonable check included in the act, which is the access to the common area, and then the advocate can present the identification and then proceed to the room.

**Mr Wessenger:** I assume that's the way it would work. An advocate would come in—

**Mrs Sullivan:** It's not.



**Mr Wessenger:** —identify himself and then—

**Mrs Sullivan:** It is precisely not that way. The advocate now, in a facility—this is the whole reason for the amendment—can proceed directly from the entrance of the building into the private room of the patient, into an examination room and into an ICU. There is no check and no balance. There is no requirement even for stopping.

**Mr Wessenger:** If I might respond to that, if you look at subsection 16(2), the advocate “shall, on request, present identification” shows clearly that no advocate could—

**Mrs Sullivan:** Upon request. The advocate can proceed—

**Mr Wessenger:** On request, that’s right. Any hospital person can use the same control over an advocate that he has over any person wandering in to visit a patient.

**Mrs Sullivan:** The advocate can proceed directly without anyone in the institution or facility knowing that this advocate is intending to go to the room at any time the advocate wants to go to the room. It’s only when challenged, if there’s a check, that the advocate is not allowed, under this act, and in fact is empowered and given the right to enter at any time according to the advocate’s determination of what is reasonable. The advocate’s determination of what is reasonable may be 2 o’clock in the morning, because that’s when the advocate may suspect that abuse is occurring.

**Mr Jim Wilson:** Again, the amendment seems reasonable. This stuff isn’t going to work for the vulnerable person unless there’s harmony between the staff and the health care practitioners in dealing with a facility, for example. I think what we’ve been trying to do through many of our amendments is to take out any potential for adversarial relationships flaring up.

I think treating a facility the same as a controlled-access residence is reasonable in this regard. If the advocate does sneak in and it’s only upon request that the advocate has to show identification—we all know how busy facilities can be and how you can just walk up to any room in many of our hospitals, particularly in rural Ontario. We don’t have the security you may have in Toronto hospitals, for instance.

I think you add suspicion, you introduce an adversarial relationship there. When the staff or the medical team finally discover that there’s an advocate standing in the room and you introduce the scenario of saying, “Who the hell are you in this person’s room?” it’s only reasonable that the advocate be required, as Mrs Sullivan said, to sort of check in with the facility and the staff. They can’t deny access to the vulnerable person. The objectives of the act are met in terms of providing advocacy services.

1450

I think you also want to balance how many rights you’re trampling on in terms of vulnerable persons’ rights. By allowing someone to sneak into their rooms undetected, which is the worst-case scenario, and that’s what we’re dealing with as legislators, you’re infringing on the vulnerable person’s right to privacy, you’re infringing on the vulnerable person’s right to be free from state intervention, you’re interfering with that person’s right of freedom in a general application, and I would go so far as to say you’re

interfering with the freedom of that individual to associate with persons with whom he or she wants to associate.

I could probably list more if I had my Charter of Rights and Freedoms with me, but it seems to me that a lot of the rights we take for granted, you’re infringing on more of those, and masking it in you want the ability to save the vulnerable person.

Mrs Sullivan touched on it too. Save the vulnerable person from whom, or which persons? First, in a facility, unless you’re prepared to state otherwise, everyone is working for the common good of the vulnerable person. That’s the assumption you should make, and you shouldn’t have legislation that leads people who read this legislation to assume that you don’t have that faith in our facilities and in the staff and the medical teams there.

**Mr Owens:** Just really quickly, I think we’ve seen quite clearly the results of not having this type of legislation. We’ve seen the St John’s training schools, we’ve seen the abuse going on in nursing homes, and I’m not sure why you feel that in order to—in your view, you want to protect people’s rights. Does that include the right to be abused? That’s clearly what you’re saying here. You’re saying that the advocate should not have the right—you’re talking about entering a building at 2 o’clock in the morning and in fact that may be a reasonable time. It may be 2 o’clock on Saturday morning when the abuse is taking place, so why is that reasonable?

Why do you want to tighten down the rights? We’ve seen the examples of group homes, and again, St John’s training schools, where this type of legislation wasn’t available to these people. How many more cases of sexual abuse do you want to have reported in the press before we can get this stuff sorted through?

You talk about rights. Yes, let’s talk about rights. Let’s talk about the rights of the victims as well. Your party, Mr Wilson, stands on its high horse and talks about victims’ rights on a regular basis, and here we’re trying to prevent victims from becoming victims and you’re saying: “No, we have to be reasonable. We have to make sure that people’s rights are respected.” What about the rights of the patients? We’re not respecting those rights by allowing this kind of activity to take place.

I think you’re missing the intent of this legislation. The unsaid allegation or accusation about case-finding, that advocates are going to be running amok in health care institutions, is absolutely inappropriate. I spoke to a number of people after the presentation from Baycrest Centre for Geriatric Care, where the allegation was actually made around, “We’re concerned that people may go about case-finding.” My concern is that these advocates are going to be so damned busy with existing things they’re not going to have time to handle their own workload, never mind having the time to sneak into hospitals and sneak into rooms.

**Mr Jim Wilson:** I appreciate your comments, but I just spent an hour on the phone over the lunch-break with a constituent of mine whose business has been closed down by a Ministry of the Environment inspector. What that leads me to think and what we must keep in mind is



that an MOE inspector, who has rights of entry, as Mr Winninger has used them in many, many other examples of existing Ontario statutes where officers have a right to enter premises, businesses or private dwellings, has real powers to issue orders, to issue in this case, over the lunch-hour, what they call an air ticket; a clean air approval certificate must be issued. But the advocates don't have those powers, nor should they.

We spent a great deal of time during the public hearings understanding what an advocate can and can't do. Mr Malkowski said it in his own remarks. An advocate simply expresses the wishes of the vulnerable person. We've talked about the fact that the advocate can't correct a lot of the situations by himself or herself, but simply express it. In the case of a facility, I would correctly make the assumption that you express the problems to the staff and try to solicit their cooperation in correcting these things.

I'm just trying to prevent an adversarial relationship occurring where you're welcoming more problems into the mix than may already be present. I think it just defies common sense not to treat facilities the same as controlled-access residences, because the advocates can't by themselves issue orders or can't do the things that in so many of these other examples Mr Winninger gave us other officers can. We have to rely on good relations there, and I think you establish good relations by having sound legislation that doesn't have an adversarial potential built into it.

**Mrs Sullivan:** I'm troubled by Mr Owens's contribution to the debate because he's basically saying that the patients' rights to privacy, and in fact the patients' rights to consent to the involvement of the advocate should be—

**Mr Owens:** That's not what I said.

**Mrs Sullivan:** It is. I want to complete this because your interpretation of the role of an advocate is quite different from what the principles that we're discussing in this bill are.

You've talked about the advocate who is able to enter a situation and take action to protect that person as if the advocate were not working in a way that we have understood an advocate should be working; that is, to assist the vulnerable person himself or herself to take action.

Now surely, if we are going to be insisting—and I hope we are going to be insisting—that this is the approach the advocate is going to be taking, not the approach of the advocate taking independent action outside of the vulnerable person, then surely the first step is to ensure that the vulnerable person indeed wants to see the advocate and consents to the advocate entering his or her room in the hospital at that particular time.

If I'm a woman and I'm in a hospital and I'm having a pelvic examination and an advocate walked into that room and said, "I think you're vulnerable," I'll tell you, I would say I'm vulnerable too, but not for the reasons the advocate thinks I'm vulnerable.

There are times when it's absolutely reasonable for an advocate to request to meet with a patient, to be identified and to say, "Do you want to see me?" But there are times when it is an extraordinary intrusion on the rights of a

person, whether vulnerable or not, to intervene and to intrude and to invade his or her privacy.

What we are asking for is a reasonable and equivalent treatment of people who are in hospitals or in homes for the aged to those people who are living in a controlled-access residence. That's what we're asking for. You've given it to one; give it to the other.

1500

**Mr Michael A. Brown (Algoma-Manitoulin):** I find this section obviously troubling. I find a lot of the bill quite troubling. I just have a short question that hopefully somebody can help me with.

Under the section as it's presently written, the advocate would have the right to go into a private room in a facility, be it a hospital or a nursing home or whatever defined under the act, if indeed he is to advocate on behalf of a vulnerable person. Could legal counsel tell me, what if in fact there's no vulnerable person there? For example, he goes in to make the determination and determines the person is not a vulnerable person. What's the answer?

**Ms Mary Beth Valentine:** I think the basic issue is, if I understood your question correctly, any time an individual asks an advocate to leave, he or she leaves. If there's no one there, there's no one there; there's not an issue. There's no case until the individual indicates a concern and engages the advocate.

I also perhaps could clarify that in all advocacy programs that have ever been analysed, 97% of issues that are dealt with are reactive. Either the individual himself asks for an advocate or someone else, a third party who is involved, and quite frankly, frequently a health care professional who's working in the same institution involves the advocate out of a particular concern.

So on the issue of determining vulnerability, I'm having difficulty in understanding the debate in order to be able to respond directly to that. The issue is, if someone is detained within a facility, if he's restrained, if he's unable to move, if he's in a position where he is highly dependent upon other people, such as many elderly people are, such as many severely developmentally handicapped people etc are, he is, by definition, vulnerable. They're highly dependent upon others.

**Mr Brown:** I guess that's exactly my problem, that this act gives an advocate the right to go into any room anywhere—

**Ms Valentine:** At reasonable times.

**Mr Brown:** Yes, at reasonable times, which, as Mr Owens points out, could be 2 o'clock in the morning for a particular instance.

**Ms Valentine:** Perhaps, as a matter of fact, I could give you examples of specific cases where having access at 2 o'clock in the morning has been extremely important to deal with an issue of abuse.

I think it's just not a black and white issue, that you could suggest that at 2 o'clock in the morning someone couldn't be abused in a facility for developmentally handicapped people or something of that sort. I'm trying to put the policy issue into perspective.



**Mr Brown:** I understand that. I'm not disputing the fact that 2 o'clock in the morning may be an appropriate time. I'm just trying to grapple with this problem that the advocate really gains his authority when there's a vulnerable person, but he decides who a vulnerable person is. If the person he has come to see is not a vulnerable person, how did he have authority to go in there in the first place? Otherwise, an advocate has the right to go into every room in every facility under this act to determine if there's a vulnerable person there.

Is that what we're hearing here? Is that what's trying to be achieved? That would be a gross invasion of many people's privacy. I accept the fact that this isn't going to happen very often, and as Mr Wilson has pointed out, we're over here in opposition looking at the worst-case scenarios. That's our job. I'm just trying to understand what—

**Ms Valentine:** Sir, with all due respect, the worst-case scenarios are the situations where an advocate can't get in and people wind up dying.

**Mrs Sullivan:** Mr Chairman, could I request a five-minute recess?

**The Chair:** This committee will stand recessed for five minutes.

The committee recessed at 1504.

1523

**The Chair:** I call this committee back to order.

**Mr Jim Wilson:** My remarks were going to be directed to a comment Mr Owens made, if Mr Owens is available to the committee. Perhaps since Mr Malkowski is here, I just want to go back to something I found fairly disturbing in the example that was put forward first by Mr Owens—that is, that somehow the amendment, as proposed by Mrs Sullivan, would prevent advocates from visiting someone at 2 o'clock in the morning. That's a fallacious argument.

If you read subsection 17(1), it says, "An advocate is entitled to enter a facility or controlled-access residence, without a warrant and at any time that is reasonable in the circumstances, if the advocate has reasonable grounds to believe that there are vulnerable persons in the premises." I don't see how the change that's being suggested to subsection 17(2) interferes with subsection 17(1) at all, and I'd like that clarified from the government side.

**Mr Malkowski:** I'm sorry, Mr Wilson, could you repeat or rephrase that just for clarification?

**Mr Jim Wilson:** How does the amendment proposed by Mrs Sullivan interfere with the right of an advocate to enter a facility or controlled-access residence at any time he or she feels is reasonable? The example that was given Mr Malkowski from Mr Owens was that somehow this amendment would prevent advocates from visiting people at 2 o'clock in the morning if the need arose. I take exception to that example because I do not believe it to be true.

**Mr Malkowski:** I think it would be most appropriate to ask our legal counsel to respond to that.

**Ms Perlis:** Sorry, I was in a discussion with legislative counsel at the moment and I didn't hear the question. I don't know if my co-counsel heard the question.

**Ms Carla McKague:** The amendment that's proposed would not, of course, prevent the advocate from entering the common areas, the hallways of the facility, at 2 o'clock in the morning. It would certainly prevent the advocate from entering a private room, which might be exactly where the problem is at 2 o'clock in the morning, as at any other time of the day.

**Mr Jim Wilson:** I don't see that in this wording. Can you just bring me through that in the legal text?

**Ms McKague:** Subsection 17(2), as written, makes it clear that the right to enter—no, the amendment would add "facility" to "controlled-access residence" in the second section, which would then read, roughly, "The right to enter a facility under this section applies only to the common areas of the facility and would specifically exclude private rooms."

**Mr Jim Wilson:** Okay. The second part of that is, even with the amendment, the advocate still maintains the right to meet with the vulnerable person in private, because that's contained in subsection 18(2), I believe.

**Mrs Sullivan:** And in subsection 17(3).

**Mr Jim Wilson:** And in subsection 17(3).

**Ms McKague:** It's actually also contained in subsection 17(3): "The advocate is entitled to meet with one or more vulnerable persons in the facility...without interference and in private." The difficulty is that it might well be that, for instance, the vulnerable person is confined to bed and the only place one could meet in private is in the vulnerable person's room.

**Mr Jim Wilson:** But given the role of the advocate, it still makes sense in my mind that the courtesy perhaps, as it were, be extended to the facility that it know the advocate is in the facility.

**Ms McKague:** There is an issue here, I believe, of the confidentiality of the relationship between the advocate and the vulnerable person. It might well be the vulnerable person's wish that other people in the facility not know that he is using the services of an advocate, and I would think he's entitled to that in the same way as the right of confidentiality around medical information includes confidentiality of the fact that you're even seeing the doctor.

**Mr Jim Wilson:** Given that efforts have been made over the years, in more recent times in particular, to sort of beef up security in hospitals, as an example, and nursing homes, so you can't just have people walking to people's rooms unannounced and without the awareness of the staff. I see this still as problematic.

Even in the Alliston we don't have the best security, but we've had reasons in the last three or four years to beef up security, so now we have a couple of security officers. They try to do their best to make sure people aren't just wandering into people's rooms. Now you're telling me you're going to have an advocate who can legally just wander into people's rooms.



**Ms McKague:** The advocate, I assume, would be subject to exactly the same security precautions as anyone else. Frankly, I would rather have an authorized advocate walking into my room than an unauthorized person off the street.

1530

**Mr Jim Wilson:** The point is that operators of these facilities, I think, have the right to know who's wandering around their halls and entering their private rooms, so doesn't it make sense that the advocate show his or her badge and then request access to the individual?

**Ms McKague:** The advocate is already obliged to show his or her badge upon request and, if approached by security, would certainly do so. We are very much aware, however, that with the history of the advocacy program in the psychiatric hospitals, for example, there have been a number of reports of repercussions taken against patients in the hospital because they have sought the services of the advocate. Staff who are threatened by the idea that the patient has gone to the advocate have in fact taken that out, and there's therefore a duty of confidentiality on the advocates in that program that if they're requested not to reveal that the patient is using the advocate services, they will not do so.

**Mrs Sullivan:** I think it's very clear that the government will not be budging, that the government will not accept what in fact are reasonable and impassioned arguments on this entire question. The amendment was put because we believe this provision will in fact interfere with rights of people who are vulnerable or people who may not be vulnerable.

Under my amendment an advocate could enter the common areas of a facility as defined in the schedule of the act and, if refused access to a patient for whatever reason—say, in a hospital the advocate was advised at the nursing station that there was a medical consultation under way with the patient at that time and the advocate could enter at a later time, that might be appropriate.

If there were an abusive situation that had been reported, that the advocate had come to know about or that had been reported to him or her, so that there was suspicion of abuse, and the advocate was refused without a reasonable excuse—the patient is asleep or the patient in a nursing home is being turned and lotions are being applied to ease bedsores, whatever—if there's not a reasonable response from the people in the institution, surely that is another ground for the advocate to in fact believe that there are reasonable grounds to enter that place and that the reports that were made to the advocate have another strength of evidence.

The advocate should then take himself or herself promptly to the justice of the peace, get a warrant for entry and probably bring back authorities who can deal with the kinds of abuse that we are concerned about. If it's sexual abuse, if it's battering, if it's physical injury to the patient, the advocate in those situations is going to, and in fact the bill provides later that the advocate should, take issues such as those to proper authorities.

We feel that the position of the advocate is strengthened and the privacy and the rights of the person are strengthened by this amendment. The government clearly is intransigent. In my view, people in Ontario are going to be outraged when they see this action of the government and the demands of the government for an unfettered right to entry at any time, with or without grounds that are fully substantiated and where people's individual privacy and, in my view, their charter rights are being infringed upon.

I think that every member of the New Democratic Party will have telephones that will be ringing off the hook as a result of this particular amendment. People will not understand the arguments that are being put forward, because in fact the arguments that are being put forward are not adequate to meet the arguments on the other side. We've heard nothing from the government to convince us that this is not an egregious error.

I'm prepared to vote on this, and I do so with enormous reluctance and, in fact, deepseated anger and disappointment.

**The Chair:** Further discussion? Seeing no further discussion, we'll proceed to the vote on the Liberal motion on alternate 2, subsection 17(2). All those in favour?

**Mr Brown:** A recorded vote.

The committee divided on Mrs Sullivan's motion, which was negated on the following vote:

**Ayes—4**

Brown, Cleary, Sullivan, Wilson (Simcoe West).

**Nays—6**

Carter, Malkowski, Morrow, Owens, Wessinger, Winner.

**The Chair:** We will proceed to the Liberal motion on section 18. Comments?

**Mrs Sullivan:** I have two motions with respect to this section. I'm not going to proceed with the first motion, which is the motion for withdrawal, but in putting it, I'd like some clarification from the parliamentary assistant to the minister with respect to the identification of premises other than premises that the advocate is entitled to enter under section 17.

We think that clarification is very important. It has not been clear throughout the public hearings what those premises are. One could assume, by example, that they could be university residences; that they could be residences of schools which have students who are 16 years of age and older, to whom this bill applies; that private homes could be included in this section; that those premises could be places of employment; that they could be educational institutions; that they could be vocational institutions where teaching is done; that they could be social or recreational centres. These are the assumptions that follow, because we've had no definition of premises.

I want to give you an example which is one I don't think we had adequate input on through the public hearings. It is the case of high schools where attendant child care workers are available for developmentally delayed children or otherwise disabled and who are now integrated into the school system. What will be the relationship



between the attendant who is hired by the Board of Education and who is certainly, in every circumstance I've been aware of, also acting as a personal advocate for the individual? In fact that's part of the job.

1540

I think most boards in Ontario, if not all, now have those integrated systems available. Do premises include high schools or elementary schools? Frequently, children who are in these attendant care or child care programs at the elementary school level are in fact over 16. What is the relationship between the advocate in that situation, the attendant care person and the vulnerable person? Is that included? Are places of employment included?

I've indicated residences at the junior school level where there are people 16 and older. I've spoken about residences for colleges and universities. What other places are included in these premises? We've not had an adequate exploration of that. We have had very little discussion of that. I think it's extremely important that not only the committee but the public understand precisely what those premises are.

**Mr Malkowski:** I appreciate your comments and the concerns you've raised. I'd like to ask that our legal counsel clarify that terminology for you.

**Ms Perlis:** You are correct. There is no definition of premises in the act. The intent is to capture private dwelling units. I would refer you to the definitions of "controlled-access residence" and "facility" in section 2 of the act:

"'Controlled-access residence' means premises, other than a facility, where one or more persons live and that are operated for remuneration by a person who controls access to the premises."

Obviously, the intention is to capture dwelling units. It refers to premises where persons live.

The definition of "facility" under section 2 refers to "a facility governed or funded under an act mentioned in the schedule" or "prescribed by the regulations made under this act." Regulations of course are not available, so the only information we have at the moment would be by reference to the facilities listed in the schedule attached to this act and the acts listed thereunder.

Whether another premise falls within the definition of section 18 is open to some question, based on whether it would fall within a controlled-access residence definition or a facility. If not, presumably it is a premise within the meaning of the act in the absence of any more specific reference to the term. However, the intent is to capture a private dwelling unit.

**Mrs Sullivan:** Because it is not defined, it would not exclude, by example, educational institutions, including residences associated with them, or schools or places of employment or places where social and recreational activities take place. There is no exclusion for access to any of those places, given this definition. It was not limited to homes.

**Ms Perlis:** No, it is not limited to homes. The example you provided of university residences might be one which would well fall within the definition of controlled-access residence, as a premise where one or persons live,

operated for remuneration by a person who controls access. I don't know what the access is now, but there was certainly controlled access to the residence I lived in as an undergraduate. It's probably changed. I think you were only allowed men in your room between 3 and 5 on Sunday or something.

No, the act does not refer specifically to any premise. It merely excludes facilities and controlled-access residences from section 18.

**Mrs Sullivan:** Then, given the involvement of boards of education today with people who are vulnerable and who are being assisted in realizing additional and further capabilities through the school system with particular devices, whether it's attendant care, whether it's special devices and so on, where do school boards fit into this situation, and what kinds of discussions has the ministry had with school boards with respect to the involvement of advocates in programs where young people are now receiving a service which is partly an advocacy service, but far more than an advocacy service? Has any discussion occurred?

**Ms Valentine:** From a policy perspective, I think, as you're aware, that there's not anyone in the room at the moment who has had the long, early background in the policy discussions. I am aware that the Ministry of Education has been involved in some of the more recent discussions—by that, I mean this spring and summer—partially when there was concern as to whether the act was going to be addressing children under 16 years of age, and partially when the issue of those over 16 was raised.

The Ministry of Education itself: I have no idea whether it has consulted with the school boards or administrators in schools etc. Their perspective was hopeful that advocates would be able to provide some assistance at times. Certainly, again, the informal types of discussions were that an advocate may be able to have information that could help to steer someone in another direction—make a referral, make a connection, those sorts of things—but if there were a particular problem, that perhaps there might be times when for a disabled person an advocate would be able to serve as a resource that is not available to people now.

The discussions, certainly, that I was involved with didn't take the tone of, "Would an advocate be able to or not able to enter into a school?" I think any school is considered a controlled-access facility. Someone can't just automatically walk into a school or into a classroom or whatever.

I don't know that I'm specifically answering your question. I'm not intending to dodge it. It's just that this is to the best of my knowledge.

**Mrs Sullivan:** I appreciate that response, but I think it really does underline some of the difficulties we're having with this bill in that we are under such time constraints. We are under such time constraints with the public hearings process where we're dealing with four bills at once, where a provision like this will affect many other areas of society and where there has been no discussion that is publicly available and no consideration of the issues and



balancing of the issues from one to the other in respect of our discussions. I think that's highly problematical and takes us right back to the whole issue of time allocations in dealing with these bills.

Had there been additional time in the public hearings, we probably would have heard from the school boards, by example, and from the recreation associations, which are moving more and more into the support of recreational programs for disabled people. We probably would have had had discussions with colleges and universities with respect to the interrelationship of advocates in terms of the work that they're doing.

Frankly, in the government's own presentations, which have been limited, really, to the minister's prepared text at the beginning, there has been no reference to anything other than the residence aspect when there are many other areas where advocacy services would be useful and helpful and where those advocacy services should be individual rather than only systemic.

In raising this whole question of what a premise is and what the parameters of this bill are, it appears that as we are now in the wee hours of concluding discussion, we find that the parameters of this bill are far greater than have been discussed through the entire public hearings process and through any discussion of the clause-by-clause so far. I think that is a terrible shame.

1550

**Ms Valentine:** Ms Sullivan, perhaps I could draw your attention to something. It certainly doesn't address the issue of schools that you were referring to, but the issue of programs, for instance, has been specifically addressed in relation to Ministry of Community and Social Services and Ministry of Health programs, because that is where the bulk of the funding comes from for rehabilitative programs, things of that sort. That's addressed in clause 36(1)(e.1).

**Mrs Sullivan:** I understand that it's included in the bill, but my point is that there has been absolutely no discussion, either of programs or premises, before the committee, and I think all members of the committee would agree with that. We have missed entire significant portions of this bill.

**Mr Jim Wilson:** Just to clarify, is Mrs Sullivan withdrawing her amendment dealing with section 18 or are we going to be voting on that, ie, to have section 18 struck?

**Mrs Sullivan:** Now that we've had the discussion, I'll withdraw it.

**The Chair:** Thank you, Mrs Sullivan.

**Mr Jim Wilson:** That makes sense, Mr Chairman, because then those of us who don't like section 18 can just vote against the government reprinted 18.

**The Chair:** Mrs Sullivan, on your Liberal motion on subsection 18(1.1).

**Mrs Sullivan:** This one I'm definitely going to be leaving in, with respect to entry to private dwellings, under section 18. I'm making an amendment that would indicate that despite the provisions of subsection 1 of section 18, which gives the advocate the right "to enter premises other

than premises," which we have just had clearly defined as private dwellings, the advocate would not be entitled to enter a private dwelling without a warrant for entry.

**Mr Jim Wilson:** I'll be supporting this amendment on behalf of my caucus. As you know, we had put forward an amendment with the exact wording as the Liberal motion, and I'll be supporting it.

A number of highly credible groups suggested to this committee that a warrant be required for entry into private dwellings and that emergency entry can be made by the police using normal police powers of entry without a warrant. I think this is an important safeguard. In spite of what other precedent might be out there, I think it's a tremendous intrusion upon people's rights to privacy to simply have advocates deciding for themselves to enter private premises, and there must be a safeguard. The warrant, I think, is sufficient and necessary.

I don't think you can blame us for thinking this way when we don't have a high degree of confidence in the training and role of advocates, because clearly from the clause-by-clause discussions we've had to date and the committee hearings, as Mrs Sullivan has correctly pointed out, the scope of what these advocates are to do, the scope of their duties seems to vary depending on whom you talk to on this committee. When you talk to some of the government members, it seems that advocates are envisioned to have more powers than what the act actually gives them, and we've yet to see any amendments really dealing with the training and qualifications of advocates.

Given that low degree of confidence in the role of an advocate, I think it's reasonable to protect the public and to protect their right to privacy by requiring advocates to appear before the judiciary and obtain a warrant.

**Mr Winninger:** We discussed this issue a little yesterday. I think I still hold to the view that this section does meet your concerns, because if the property owner declines entry, then the advocate does have to seek a warrant under these circumstances. Why force every advocate to go and get a warrant, when the property owner might be quite amenable to offering entry? I don't see it as being necessary.

**Mr Malkowski:** The government will not be able to support this motion, for the same basic reasons as were cited before. The advocate needs to be able to contact the vulnerable person, regardless of where he or she lives, but as mentioned, he cannot use force. There is also no penalty to the owner of the dwelling should he refuse entry.

**Mrs Sullivan:** I want to respond to the point made by Mr Winninger, who says that if the owner or occupier of the private dwelling refuses access, the advocate cannot enter without the warrant. In fact, that's not what the bill says. The bill says there's an entitlement to entry, whether or not there's consent, and that entitlement is a very different situation from the owner or occupier of a dwelling saying: "Hello. You're an advocate. I'm glad to see you. Please come in."

I think there's a very different scenario that we're looking at here. Many of the arguments that I would be placing on this motion with respect to the invasion of privacy and property were put with respect to the previous amendment,



but the entitlement here is very different from the provision of consent.

**Mr Jim Wilson:** Just following on that, and also in response to Mr Winninger's comment, I can clearly see the case where perhaps an owner or occupant of a private dwelling isn't aware of the right to refuse the entry of the advocate. That raises the question, are advocates required to inform the owner or occupant that he or she has the right of refusal? If not, when seeing someone in a power position come to the front door and demand entry to their house, people may be inclined more often than not to say, "Well, I guess you can do this, so come on in and do whatever it is you have to do."

I want to know whether there's a requirement of the advocate to inform the occupant or owner of the right to refuse entry.

**Ms Perlis:** The bill does not specifically impose such a requirement on the advocate.

**Mr Jim Wilson:** I was aware of that, but I'm just wondering—

Interjections.

**Mr Winninger:** You're so rhetorical.

**Mr Jim Wilson:** I'm just wondering if Mr Winninger is aware of that and if the government is comfortable with that.

1600

**Mr Winninger:** I'm comfortable with the provisions under section 19, which basically entitle the owner to request, I suppose, that the advocate go and get a warrant.

First of all, I think there are many safeguards built in here for the property owner. The advocate has to have reasonable grounds to believe that certain facts exist, as set out in clauses (a) through (c). So there is a test there. And if the owner stands his ground, then the advocate has to seek the warrant. I don't know that you need to spell out property owner rights, although in canvassing politically I've gone to many apartment buildings run by Conservative or Liberal owners who didn't want to let me in and often I had to point to the text of the Landlord and Tenant Act, which said I could get in there to do my political canvassing.

**Mr Jim Wilson:** Into the common areas, you might recall.

**Mr Winninger:** No, to get to apartment buildings.

**Mr Jim Wilson:** Yes, but only to the door.

**Mr Winninger:** To get to apartment doors.

**Mr Jim Wilson:** In the common areas; read the act.

**Mrs Sullivan:** That's right. The act says the common areas.

**Mr Winninger:** Right, but all I'm saying here is that there is a safety valve which requires the obtaining of a warrant. I think there are protections built in. I don't know why you would want to change those protections.

**Ms Jenny Carter (Peterborough):** Maybe we should just pursue that analogy. I mean, if you get in because you're canvassing and you knock on the door and the person opens the door, he or she can invite you in and have a

chat and give you a cup of tea or slam it in your face. We're in exactly the same situation here, because if the person in that room doesn't want to speak to you, you go away. If they want you to come in and have a cup of tea, you do that too.

I must say that I feel we're getting very much out of proportion here in our consideration of invasions of privacy, because any inconvenience or bother that is going to be caused by somebody knocking on a door and asking if he may come in is so minimal, compared to the opposite possibility, which is that there might be somebody in that house in dire need of assistance, and we're looking here at setting up barriers.

Do we really have such wonderful rights to privacy? I get people phoning my house wanting to sell me things, I get people coming to the door on all kinds of nuisance errands, and all I have to do is say, "Go away," but they've already interrupted me at supper or whatever it is. That happens all the time, and that's all that could happen in this case. You might let them in to see somebody in the house, and, as I said, all that can happen is that either they have a conversation with that person or they're immediately asked to leave. What is the big deal here? I just don't understand it.

**Mr Jim Wilson:** I purposely used the terminology in my remarks, someone who's in a position of power. A canvasser's not in any position of any power, and neither is a solicitor at your house.

**Ms Carter:** Neither is an advocate. They leave on request.

**Mr Jim Wilson:** I would think an advocate showing up with a badge with this act behind him might be rather intimidating to some people, and yes, I happen to hold the right to privacy—

**Ms Carter:** Jehovah's Witnesses might be intimidating to some.

**The Chair:** Please, Mrs Carter, Mr Wilson has the floor.

**Mr Jim Wilson:** I happen to have high regard for the right to privacy and think that errors have been made in the past and legislation has been passed that has infringed upon that, I think very much unnecessarily.

But having said that, Mr Chairman, I am prepared to vote on this, because I sense the government's not going to support this amendment.

**Mrs Sullivan:** Just before we proceed to a vote, I want to correct the impression Mrs Carter has left that the property owner can say, "No, I don't want to see you; you're interrupting me," and so on.

Interjection.

**The Chair:** Mrs Carter, please. Mrs Sullivan has the floor.

**Mrs Sullivan:** That is not the case. It's the vulnerable person who must consent to the entry, and in fact the property owner, the person who owns the facility, the parent of the child or the son or daughter of the senior citizen has no right to exclude entry to an advocate. The entitlement is there under the bill. We are saying that with this amendment the



advocate, to have that entitlement, should have a warrant for entry. That's what the police have.

**The Chair:** Further discussion? Seeing none, we'll proceed to the vote. On the Liberal motion on subsection 18(1.1), all those in favour?

**Mrs Sullivan:** A recorded vote.

The committee divided on Mrs Sullivan's motion, which was negated on the following vote:

#### Ayes—4

Brown, Cleary, Sullivan, Wilson (Simcoe West).

#### Nays—5

Carter, Malkowski, Owens, Wessinger, Winninger.

**The Chair:** Liberal motion on subsection 19(1).

**Mr Jim Wilson:** Mr Chair, did we vote on 18?

**The Chair:** That's the whole section. We've agreed to leave the sections open.

**Mrs Sullivan:** In subsection 19(1), we've added areas to the rationale for a justice of the peace to issue a warrant. In fact, it expands the opportunity of an advocate to receive the warrant. The expansion in both this amendment and the next one—these are separated because we have parts of section 19 that are still left in. The rationale for the granting of the warrant more clearly coincides with the purposes of the advocate's involvement, so this motion and the next motion, but in particular this one, would expand the rationale for the issuance of a warrant to an advocate rather than simply saying the warrant should only be issued under circumstances. These are, in fact, additional circumstances under which the warrant could be issued.

**Mr Malkowski:** The government will not be able to support the motion.

**Mrs Sullivan:** Could we have a reason?

**The Chair:** Would you care to respond, Mr Malkowski?

**Mr Malkowski:** For the following reason: We believe the reasons are adequate when read in conjunction with section 18 and reasonable grounds in section 18 for warrantless entry.

**Mrs Sullivan:** I would appreciate further expansion of that rationale.

**Mr Malkowski:** Maybe I can ask that we have legal interpretation of that from counsel.

**Ms Perlis:** Section 19 requires that the justice of the peace be satisfied that the advocate has been prevented from entering in accordance with subsection 18(1). Subsection 18(1) imposes the duty on the advocate essentially to have reasonable grounds to believe that either (a), (b) or (c) is in existence in order for the advocate to enter without a warrant. So the justice of the peace, with reference to clauses 18(1)(a), (b) and (c), must be satisfied that the advocate has reasonable grounds to exercise a right of warrantless entry.

1610

**Mrs Sullivan:** The justice of the peace, therefore, does not have to be satisfied that there are reasonable grounds to believe that there is a risk of serious harm to the

person, that the services of the advocate are wanted, desired, wished for, and in fact that the purposes of the act, which would still remain as included in (b), would be fulfilled?

**Ms Perlis:** I believe this section states that the justice of the peace would have to be satisfied that the advocate has reasonable grounds to believe that he or she is entitled to enter without a warrant under the grounds enumerated under subsection 18(1) or has been prevented from meeting with the person without interference and in private under subsection 18(2), but the reasonable grounds test would apply to the advocate's possession of those reasonable grounds.

**Mrs Sullivan:** Well, under subsection 17(1) the reasonable grounds are that there's a vulnerable person on the premises, whether or not the vulnerable person requires assistance or wants it.

**Ms Perlis:** Correct. I was referring specifically to section 18, but you're also correct. The justice of the peace would have to be satisfied that the advocate had reasonable grounds under subsection 17(1) to believe that there were vulnerable persons in the premises.

**Mr Jim Wilson:** With respect, I think we're splitting hairs here. I think the government bill covers the ground precisely, as contained in the Liberal motion, and I'm quite satisfied with the wording contained in the reprinted bill. I won't be supporting the Liberal motion on that account and would ask Mrs Sullivan to take our word for it that it's well covered already. Otherwise, we're going to be here for ever.

**The Chair:** Further discussion? Seeing no further discussion, we'll proceed to the vote on the Liberal motion on subsection 19(1). All those in favour? Opposed?

Motion negated.

**The Chair:** Next is the Liberal motion to subsections 19(6) to (8). Comments?

**Mrs Sullivan:** Once again, these are further additions to the conditions with respect to the warrant which would indicate that (a) the warrant would enable the advocate to enter the common areas of the premises, (b) a private room in a facility or controlled-access residence or a private dwelling unit could not be entered without the consent of the vulnerable person, and (c) once again that the advocate must leave if the vulnerable person indicates that he or she does not want the services of the advocate.

I point out to you that subsection 18(2) is not now included in the warrant provisions, and this would enable the advocate to enter the premises even if the person indicates that he doesn't want the services of the advocate and that therefore the act would require that the advocate must leave the premises promptly.

**Mr Jim Wilson:** We'll be supporting this amendment but I don't really think it's necessary to stretch out this debate. Many of the points I would make are similar to those made previously in our discussion regarding access to facilities and controlled-access residences. Suffice to say that we support the amendment, although I suspect it's not going to be adopted by the government.

**Mr Malkowski:** The government will not be able to support this amendment for the following reasons: This would have the effect of removing all rights of entry to a private dwelling, even with a warrant, and in addition would require the consent rather than the consent and acquiescence of the vulnerable person. In addition, this would, for instance, prevent the advocate from entering if the vulnerable person in fact does not indicate consent or refusal.

**Mr Jim Wilson:** If I may, Mr Chairman, I'd like at the very least to congratulate my colleague from the Liberal Party, Mrs Sullivan, for having tried in vain with three or four different approaches to get what we want to see in these sections of the legislation. I commend her for her valiant efforts and I'm sure the history books will note such.

**Mrs Sullivan:** If not the news column for the paper.

**The Chair:** Further discussion? Seeing no further discussion, we'll proceed to the vote on the Liberal motion on subsections 19(6) to (8). All those in favour?

**Mrs Sullivan:** Recorded vote, please.

The committee divided on Mrs Sullivan's motion, which was negated on the following vote:

#### Ayes—4

Brown, Cleary, Sullivan, Wilson (Simcoe West).

#### Nays—6

Carter, Malkowski, Morrow, Owens, Wessinger, Winninger.

**The Chair:** Next we'll proceed to the Liberal motion on subsection 24(2). Comments, Mrs Sullivan?

**Mrs Sullivan:** This amendment is put forward because we're now moving into the entire question of access to clinical records, medical records, records maintained in any of the facilities, programs, controlled-access residences and so on.

We have heard today that—in fact we don't know what programs are included in this right to access of information, whether those programs will include educational programs, vocational programs, housing programs and recreational programs. We do not have the full extent of information before the committee about what access to information will be provided in this bill without the person's consent. We don't have information about the full nature of the premises from which that information can be taken, what controlled-access residences, for example, would be included.

We also have grave concerns about third-party access to private medical and clinical records which would be in the custody of a facility. That's the reason for this amendment being put forward, and we feel strongly that the original portion of the bill is too broad and we have too little knowledge about its effect.

1620

**Mr Malkowski:** The government will not be able to support this motion for the following reason: It would be difficult, if not impossible, to provide uninstructed advocacy without access to records concerning the vulnerable

person. Also, non-instructed advocacy in fact will occur only where there is a risk of serious harm.

**The Chair:** Seeing no further comments, we'll proceed to the vote on the Liberal motion on subsection 24(2). All those in favour? Opposed?

Motion negated.

**The Chair:** Next, the Liberal motion on subsection 24(3). Comments?

**Mrs Sullivan:** My comments with reference to this motion in fact relate to the vote on the last motion. We're hopeful that there will be a fuller examination, and there are other sections of the bill where we'll be able to do that with respect to the entire issue of providing consent, of substitute decision-making for consent or of access to medical, clinical or other records without consent, either from the vulnerable person or from an appropriate substitute.

I'm withdrawing this motion—there was a misunderstanding when it was drafted—and I will be withdrawing the next motion, but I hope that we will be able to have that discussion. We have major concerns about the entire access-to-records question.

**The Chair:** So you're withdrawing subsections 24(3) and 24(4).

**Mrs Sullivan:** Subsections 24(3) and 24(4).

**The Chair:** We'll now proceed to the Liberal motion on section 24.0.1. Comments?

**Mrs Sullivan:** Have I read this into the record?

**The Chair:** Yes, you have.

**Mrs Sullivan:** I suppose this motion is probably as good a place as any to start in terms of the discussion about the entire access-to-records issue. We know that for many years there has been a changed attitude to access to records generally of people, whether capable or incapable, in the medical field. It's really fairly recent practice that physicians share portions of the medical or clinical record with patients themselves and that those records indeed are not totally considered and only considered a physician's property or the property of the facility.

I think it's a very positive move that the thinking has changed so that the records indeed are available to the person who is concerned, to whom treatment is being provided, who has consented to that treatment, and that the patient can himself or herself determine the disposition or use of those records.

There are very few other statutory provisions that would require or even promote the dispersal of individual patient records on a statutory basis. I believe one of the very few is the Workers' Compensation Board provision. There are limitations on where and how those records can be distributed, how they can be used, and there are conditions with respect to privacy associated with their use. There are certainly other provisions in the Mental Health Act that are considerably important and that were developed after an enormous amount of thought and work in that area.

One of the essential issues in determining the provision of and the ability to access records relates to a person's ability to consent to that access. This amendment is designed



to provide a detail of the capacity of the person to consent to a third person having access to those records. I think this is important to be included and it's important that the person who is providing that consent should have every essence of appeal and every check available to him or her if there is a determination made that the person is incapable of consenting to those records; therefore, other steps in the bill can fall into place.

The records can be accessed without consent and they can be disposed of and communicated to other people with minimal limitations and without consent. As a consequence, I wanted to underline the importance of the test of capacity for consent to access to records and provide a method whereby the person would have redress if a determination was made that the person was incapable of consenting.

The rationale for the bill: I think it is straightforward in terms of indicating the issues, the test by which the person could be judged capable or incapable and the option of an assessment through an assessor under the Substitute Decisions Act. We would certainly like to know more about who, what, where and when, but there is the protection that the advocate can obtain and must obtain an assessment so that the advocate himself or herself is not making that capacity determination, and there is a right of appeal if the vulnerable person disagrees with that determination and a stay on the ability of the advocate to act until all of those rights in that process are through.

1630

I think this is an important amendment. I think it fits well with the Bill 109 provisions with respect to capacity to consent and issues in Bill 108 which will be coming forward, indicating, by example, that a person can be capable of making decisions although that person may not be capable of personal care him or herself.

This amendment also does not eliminate the role of the advocate in assisting that person to express and to understand the issues associated with providing consent. There's no limitation on the advocate's involvement with the person. It assumes that the person will be making the decision, with or without the involvement of the advocate.

**Mr Jim Wilson:** Members will note that we had drafted a similar amendment to the amendment now proposed by Mrs Sullivan. Subsequently we've withdrawn that amendment. The only difference between the Liberal amendment and the PC amendment was our stipulation that under the appeal process the vulnerable person also be advised of the right to have a lawyer.

Again, echoing what Mrs Sullivan has already stated, we feel that the access to records and the power given to the advocate in this section of the bill is really quite overwhelming. I think the motion, if considered by reasonable people, tries to build in some safeguards, tries to ensure that if the person is deemed to be vulnerable by the advocate, there's a check on that by an assessor.

You may have a case where a person is capable but not really able to consent to advocacy services, or certainly to consent to an access to records by an advocate, and there-

fore the advocate may assume that person is vulnerable and incapable.

Again, given that we're unsure of the training of advocates, and going back to the discussion we had during public hearings on the difficulty in properly assessing individuals, it seems to me that it's reasonable to have a check in here, as suggested in this amendment. We'll certainly be supporting the amendment.

**Mr Malkowski:** The government will not be able to support this motion for the following reason. The motion is not necessary and could in fact result in an inordinate amount of time spent determining the question of records access. It's not necessary to have a process around determination of capacity to give access to records. The important question here is that of capacity to instruct the advocate. It should also be noted that currently there is no test, under the Public Hospitals Act, for example, of a patient's capacity to authorize third-party access to records.

**Mr Winninger:** Just a brief addendum to what Mr Malkowski said. I had some concerns about this section too, particularly if the vulnerable person may be objecting to disclosure of his or her records. But my anxiety, I think, was set to rest by reference to section 15.1, which we've been over before. Basically, it provides that an advocate providing advocacy services to a person "shall not do anything that is inconsistent with the person's instructions or wishes," and that would have to extend to access to records as well. So I think there's a safeguard there for the vulnerable person that puts certain constraints on what an advocate is able to access by way of records.

**Mr Jim Wilson:** I just have a question on section 24. Are the records on an individual which are contained in a private medical practitioner's office covered under "facility"? I just wanted to clear that, because I think I asked a similar question during public hearings. "Facility" really is a hospital, nursing home and public facilities as such. That's the only question I had. I think I've just answered my own question through some nods from the government side.

**Mr Malkowski:** Yes, and just for further clarification, I can refer that to our legal counsel.

**Ms Perlis:** That's correct. The reference to "facility" is to facilities that are funded or regulated by any of the acts listed in the schedule, and essentially we're talking about hospitals and other institutions.

**Mrs Sullivan:** I'm interested in the point Mr Winninger made with respect to the question not being the capacity to consent but the capacity to instruct. In fact, the request for access to the records comes not from the patient but from the advocate, and the advocate is then the prime mover of this action.

It is the advocate who is asking the consent of the person, to the best of the ability of that person to express that consent, so that the advocate can then take action, which is to access that record. Once that record is accessed, the advocate has powers to use that record in various ways. The consent, therefore, to the access implies an instruction, but it is not the only portion of the decision that's being made. The consent is a different action that's



being taken by the person than the instruction which will follow. The instruction which will follow will come as a result of the advocate having received the record.

**The Vice-Chair (Mr Mark Morrow):** Any further comments or questions?

**Mr Malkowski:** I'd like to refer that to legal counsel for clarification.

**Ms Perlis:** Nevertheless, the action of the advocate in seeking to access a record with the consent of the vulnerable person is ancillary to the provision of advocacy services to that person. Therefore, the advocate must already have received instructions from the person, at the very least, to engage him or her in providing services in an instructed situation. So the advocate does not obtain consent to access a record, then go and access the record in the absence of providing services to that person. That's a condition of section 24.

1640

**Mrs Sullivan:** I think that's one of the reasons this amendment is here. An instruction from a person which says to an advocate, "I need your assistance in this area to do certain things," is not an instruction to an advocate to do things such as obtain without additional consent and then use medical records with a separate consent.

In fact, I think the situation is that the original instruction, which may be vague—it may be quite detailed, but it may be vague—is by itself an adequate consent for an access to a record which includes deeply private and personal information about that individual.

It may also, depending on the circumstance, include deeply private and personal information about that individual in relation to other people. I think, by example, of situations where, as part of a medical, clinical record, a physician may indicate that there are stresses within the family that are contributing to circumstances that may or may not be adding to an illness or a disability or a response. They may not be situations which would lead to an accusation of abuse, but indeed there is more to a clinical or medical record than simply, "On Tuesday John received a polio shot, and on Wednesday John received a prescription for penicillin."

The information that's included in those records is highly personal, and, in my view, a specific consent and a specific undertaking that the person knows what that consent involves is very necessary. For a person who's not vulnerable, we would not ask less.

**Mr Jim Wilson:** I would like to know, first, why the government would object, particularly in the Liberal motion, to the appeal provision and the notification of the finding of the assessor in that case, and, second, why it doesn't want an assessor either reconfirming or turning down the finding of the advocate.

One of the counsel for the government today referred to professional advocates. The sentence used was: "I'd rather have a professional advocate coming into my room than somebody wandering in off the street." I recall yesterday having the argument that these people weren't professionals, that we couldn't have a disciplinary body for them because they weren't professionals and this wasn't a pro-

fession, so I can't help being suspicious about a lot of this stuff when little things slip out, whether intentionally or unintentionally, from government members about what is behind this and what the true intentions are.

It's prudent for you, as members of a provincial Parliament, to build into this as many safeguards as possible. People aren't going to go running to the Advocacy Commission with their complaints; they're bloody well going to pick up the phone and blast an NDP member about what in the world these advocates are doing in their lives. That's before we get around to repealing all this stuff.

Having said that, I'd like my questions answered, because I thought long and hard about this when we were drafting a similar amendment. I find it all to be very reasonable, but I also find that, to date, my judgement of what's reasonable hasn't been matched by the government's judgement of what's reasonable.

**The Chair:** Further discussion?

**Mr Jim Wilson:** I'd like an answer to those questions. I had two questions in that rambling.

**The Chair:** Is there a response to Mr Wilson?

**Ms Perlis:** Could he repeat the questions?

**Mr Jim Wilson:** I don't think you should answer it, first of all. I think it should come from a political member why they object. For instance, I can see People First, who object on a first basis. They object to being labelled vulnerable. Now they're labelled vulnerable and people have access to their records and an advocate can disseminate that information. Why not give them at the very least—you wouldn't give them anything else—the appeal process so they can take the time that will be required to communicate the fact that they're not vulnerable? Give them the appeal process so that they have the opportunity to be heard.

I think it's just very reasonable. You've not really been responsive at all to much of what we heard from them on two occasions, and People First come to mind when I read this very reasonable motion that's been tabled.

**The Chair:** Response?

**Mr Jim Wilson:** The silence—

**The Chair:** No silence.

**Mr Winninger:** I don't have any difficulty with this, because I can distinguish situations where you do need an assessment and a review-type arrangement as to capacity in cases where you're being admitted to a mental facility against your will, in cases where you're going to be treated against your will, in cases where you're deemed to be incapable and you're going to be subject to a guardianship order or possibly, I suppose, validation of power of attorney. These are more intrusive procedures where you may well want some safeguards as to a finding of incapacity.

Here you've got an advocate who's there to help a vulnerable person and is seeking the necessary information to enhance his or her ability to help that vulnerable individual. I don't see the need for the kind of safeguards that you do, and I guess we're just on different wavelengths when it comes to that issue.



**Mr Jim Wilson:** Just dealing with this whole issue of access to records on it, I say with respect to the government members, I don't think you appreciate the regard that's held by the public for the right to privacy. I went through it when I worked for the federal government and we fooled around with social insurance numbers. You must know, through people in your own offices and as a lawyer, the high regard people have for this. I think the onus is on legislators to do everything they can to say, "Yes, advocates must have access to records to do systemic advocacy and to help vulnerable people, but can we not agree to put in the safeguards?" People do have a tremendous and very deeply held respect for privacy.

I think of that in the case of people living with AIDS and the issues we're dealing with in the 1990s and we'll deal with in the next decade of insurance companies and some of the terrible things we've seen in the United States with information coming out of private records and decisions being made in board offices of insurance companies, which is abhorrent.

There's a slippery slope here. I can think of many examples, but you don't have the necessary safeguards in dealing with people's private information held by a facility or a controlled-access residence. I think the state has that obligation.

If you want to stand this down and survey your constituents, I can bet they would come back and overwhelmingly say, "Yes, do everything you can to protect our privacy and try and come up with a reasonable balance." I don't think the bill as it stands in the reprint is reasonably balanced. I think we need some safeguards.

**Mr Wessinger:** I would just like some clarification from counsel with respect to some interpretation of this whole question of access to records. It would seem to me the vulnerable person has a fair amount of protection here, but maybe I'm wrong, so I just ask the question to clarify.

If the vulnerable person expresses a wish not to be served by an advocate or not to have the advocate do anything on his or her behalf, does that apply to an incapable vulnerable person expressing a wish, or just to a capable vulnerable person expressing a wish?

**Mrs Sullivan:** That's part of the question.

1650

**Ms McKague:** I think the answer is found in Mr Winer's favourite section, section 15.1, which, to remind you once again, reads, "An advocate who is providing advocacy services to a person shall not do anything that is inconsistent with the person's instructions or wishes."

First of all, a wish to discontinue the advocacy service would certainly fall within that description and, second of all, this section does not say "a capable vulnerable person." It says "a vulnerable person." Even an incapable vulnerable person may, on my reading of the act, decline advocacy.

**Mr Wessinger:** Thank you. That was my interpretation, but I just wanted some confirmation.

The second question relates to the question of whether a person is capable or not. Let's just say the situation involves a request for the records of a "incapable vulnerable

person" being received. Wouldn't the facility have to make its own assessment of whether that person was capable or not capable? Is that correct?

**Ms McKague:** If it were obtained under the consent of the vulnerable person—

**Mr Wessinger:** I mean without the consent.

**Ms McKague:** Without the consent of the vulnerable person, the advocate would have a right, in the situation of non-instructed advocacy—where there's a risk of serious harm, the advocate has that right without consent in the non-instructed situation.

In the instructed situation, if you have a person who's capable of instructing you and capable of consenting to release, we have no problem. The problem that would arise, in my opinion, under the proposed amendment would be where you have someone who is judged capable of instructing an advocate but incapable of consenting to release of records.

If the person, though incapable of consenting to release, wanted the records released, there would appear to be no way under the act for that to happen. You would have a deadlock where the person could instruct, so that the advocate couldn't obtain the records through the non-instructed section but couldn't consent, so the advocate couldn't get the records through the instructed section either. If the person said, "No, I don't want you to get my records," then the advocate couldn't do that, whether the person was capable or not.

**Mr Wessinger:** What would happen in the circumstances where there was a dispute with respect to the question of whether the person is incapable of giving or refusing consent? How would that be resolved? Is there a way?

**Ms McKague:** I can't give you the answer to that immediately. Perhaps you would be willing to wait while I do a little conferring and could proceed, and I can come back to that question.

**Mr Wessinger:** Yes, I'd appreciate that.

**Mrs Sullivan:** The issues that we're discussing here, I think, are important. The advocate is the person who in fact is now making the judgement with respect to the vulnerability of the person. A vulnerable person is defined as a person who has difficulty expressing his or her wishes or ascertaining or exercising his or her rights or who is unable to do so.

A vulnerable person is not necessarily an incapable person. However, under this act the advocate is also making decisions with respect to the capacity of the person. If the advocate is making decisions with respect to the capacity of the person as well as the vulnerability of the person, then the advocate, in making those decisions, can in fact override what the person's own view of himself or herself is, if the person says, "Yes, I'm vulnerable, but I'm not incapable and I want some mechanism to enable me as a capable person who has a difficult time expressing myself to be assessed, so I can prove that in fact I can consent to a third person accessing my medical records or other records and using those records in a way in which the advocate can do, if the advocate believes I am incapable of instructing



the advocate in any way the advocate sees fit, believing that the advocate is working for me.”

**Mr Jim Wilson:** I couldn't agree more with what Mrs Sullivan has just said. With the powers that this act gives to the advocate, we have essentially what I call one-stop decision-making and it's with the advocate. Again, I plead the case that there should be, at least in the case here of access to records, an appeal process and there should be a qualified assessor involved because—if the answer to Mr Wessenger's question is ready, I'd be very interested in hearing it, because it was a question I was going to ask a few minutes ago myself.

**The Chair:** Is the answer ready?

**Ms McKague:** I'm sorry. I have to wait to speak to Ms Perlis.

**Mr Winninger:** We talked about section 15.1, but I'd like to come back to a point that counsel made after that. Under the uninstructed advocacy provision in subsection 24(2), one of the criteria, as I read the section, that has to be present is a risk of serious harm to the health or safety of the vulnerable person. We've had much debate about the emergency provision in the Consent to Treatment Act, Bill 109, and the need for expedited procedures to deal with emergency treatment. If indeed there is a risk of serious harm to the health or safety of the vulnerable person, we can hardly expect to delay the access to records in the way your recommended amendment delays access to records.

**Mrs Sullivan:** Just for Mr Winninger, who goes back to 15.1(1), the access to records is not from that section, the access to records without consent comes from 24(2).

**Mr Winninger:** That's what I just referred to, but I'm saying that 15.1 limits the ability of an advocate to do things against the wishes of the vulnerable person and that applies to 24(2) as well.

**Mrs Sullivan:** But in fact now we're not talking about doing things against the wishes of a vulnerable person. Subsection 24(2) says there must be explicit consent, and if there isn't explicit consent to access the records, the advocate has to believe that the vulnerable person is incapable, ie, make a judgement about the capacity of the person. I am suggesting that this amendment will provide a guideline on what is appropriate capacity about which those judgements can be made and in fact requires that there be some expertise in making that judgement.

1700

**Mr Winninger:** We're dealing with situations of risk of serious harm. This cumbersome appeal procedure, review procedure, will delay access to records the advocate needs to carry out the important work in that situation.

**Mrs Sullivan:** So the advocate can barrel ahead without—

**The Chair:** Mr Wilson.

**Mr Jim Wilson:** But maybe in the case of accessed records, the introduction of the possibility of delay isn't such a bad thing, given the seriousness and the regard for privacy of records. These are records the vulnerable person probably has never seen and has never consented to. These

are records made by strangers in that person's life at times. I don't know, when my grandmother is in a nursing home, what kind of records they keep on her. She doesn't know. But now this advocate will know, and I just find that problematic and I just simply don't like it.

**Mrs Sullivan:** It appears that there are reservations about this section among the government members as well. Should we stand it down? We haven't had a discussion from counsel.

**Ms McKague:** We have the answer to the question that was asked, if it would be appropriate at this time.

**Mr Jim Wilson:** In the answer, could you repeat the question too?

**Ms McKague:** The question was as to hypothesizing a situation in which the advocate's view was that the person was capable of consenting to access to the record and the facility's view was that the person is not capable of consenting to access; how would that difference of opinion be resolved?

The answer is that in those circumstances, under section 28 the advocate would seek a warrant for access to the record, and in order to obtain that warrant, the advocate would have to satisfy the justice of the peace that the advocate was entitled to access under whichever section was relevant. Included in that would be that the advocate had to satisfy the justice of the peace that the person was capable of giving the access.

**Mrs Sullivan:** That doesn't beg the question that we have an advocate, with or without the training and expertise, making an assessment of capacity to determine whether in fact the person is able to provide consent to access to the record under 24(2)(a). I don't know what kind of courses we're going to be giving advocates, but I'm telling you, they're going to be taking 20 years in school to cover all the occasions here. Why not involve people who are specifically trained as assessors in providing due process for the person whom an amateur advocate may consider incapable but a person who is trained in the area may say is capable?

**The Chair:** Further discussion? Seeing no further discussion on the Liberal motion on section 24.0.1, we will now proceed to the vote.

**Mrs Sullivan:** Recorded vote, please.

The committee divided on Mrs Sullivan's motion, which was negated on the following vote:

#### Ayes—3

Cleary, Sullivan, Wilson (Simcoe West).

#### Nays—6

Carter, Malkowski, Morrow, Owens, Wessenger, Winninger.

**The Chair:** We will now proceed to the Liberal motion on 24.1. Comments, Mrs Sullivan?

**Mrs Sullivan:** This section relates, again, to the request for access to records, and deals with the situation from the point of view of the operator of the facility or the program or controlled-access residence. It provides that



facility with a process through which it can withhold all or part of the record after an appeal, if that appeal to the Consent and Capacity Review Board is upheld. The board can then specify whether all the records should be released, a portion of the records should be released or only some of the records should be released.

This kind of protection is in fact included in other areas under the Mental Health Act and is an additional protection. In this bill we have some protections with respect to the withholding of information from the person himself, but the identification of the record, the nature of the record, is going to have to be quite specific. Without knowing the specific nature of the record, the wording of the request for the record may in fact mean that a different record or a fuller record than is actually needed for the purposes of advocacy may be brought forward.

I think those of us who are familiar with the implementation of the Freedom of Information and Protection of Privacy Act will recall that it took about two and a half years, probably, to define the nature of records and the extent of records so that the specific record that will be applied for would be clear not only to a person who was requesting the record but to the program or ministry or community that was obligated to provide that record or to appeal to the privacy commissioner to withhold the record. This is a similar kind of protection for very similar reasons, and we feel it is consistent with other provisions of health law in other acts.

**The Chair:** Further comments?

**Mr Jim Wilson:** Just a comment that I'll be supporting the Liberal motion; it's similar to the PC motion that we'll be debating next. There are some significant differences, and I'll reserve my comments for my own motion on this section.

**Mr Malkowski:** The government will not be supporting this motion. Other provisions already appropriately limit the advocate's right of access to records. The proposed amendment in fact could cause excessive delays in the provision of services.

**Mrs Sullivan:** Could we go back, then, to the comments I made with respect to the identification of the record? Does the ministry contemplate, then, that there will be a comparable process to that undertaken under the Freedom of Information and Protection of Privacy Act to describe what records are being maintained in a facility, so that there can be some precision when the advocate requests records? It's certainly not outlined in this bill. How will the advocate be able to define with any precision the specific record without the operator of the facility or the program or the controlled-access residence being able to determine whether what is in a particular computer file or filing cabinet or whatever is the record that's required, because there may be a name confusion?

Does the government contemplate a register of records? Is every hospital and every nursing home going to be required to go through the process that we went through in the implementation of the Freedom of Information and Protection of Privacy Act? If there is not that register

thinking, there will be no precision in the request of an advocate for a record.

1710

**Mr Malkowski:** I appreciate your concerns and the points you've raised. That would be left to the commission to develop under the regulations.

**Mrs Sullivan:** No. Where? How?

**Mr Malkowski:** Maybe I will just ask our legal counsel to clarify that process.

**Ms Perlis:** I'm not sure the commission necessarily will do it under regulation, but I certainly think it's within the purview of the activities of the commission to set policies and guidelines and directives respecting protocols to be followed by advocates and hopefully by facilities in working out the details of the records to be accessed by advocates. You're right in pointing out that there is no definition of records in the act for the purposes of these sections, and that will have to be worked out with the facilities and programs.

**Mrs Sullivan:** Well, if there's no provision for regulations in these areas, there is no indication that there can be any precision in determining the name of a record that the advocate asks for and there is no protection through the facility, program or residence in saying that if the advocate names a name of a record, there's a whole bunch of other stuff the facility must provide, even if it's not the specific record that the advocate wants or needs, I think there's a big problem here.

Why don't we accept my amendment? All of the provisions, then, are protected. The Consent and Capacity Review Board, which will also be looking at it and is able to agree under the Consent to Treatment Act with respect to access to records, can say: "This is the record. This portion of the record is in fact what the advocate needs and wants." There is expertise there. There is an expertise in not only the use and treatment of the records but in the working with the kinds of issues the advocate himself or herself will be working with.

I think this is a hell of a lot easier than being in a situation later where the commission, with no powers to do so, is going to have to try to impose upon a hospital certain functions of establishing a register. The commission doesn't have that power. This is an easy way to do it and to involve people with expertise.

**Mr Malkowski:** I'd like to ask our legal counsel to follow up on that concern.

**Ms McKague:** Yes, a couple of points. First, there appears to be no problem legally in defining what are the records relating to the vulnerable person. They are records which mention the vulnerable person. Whether they're in one file or scattered around the hospital, they are certainly records relating to the vulnerable person. One would also hope that there are very few facilities or controlled-access residences operating which don't have some sort of filing system which can't find the record of a particular person upon request.

Second, I want to mention a couple of points arising out of your earlier comments. Number one, you referred to



proceedings under the Mental Health Act about hearings before the review board under that act to deal with release of records. Those proceedings are only in respect of release of records to the patient. In fact the act specifically provides that where a patient is being represented by a lawyer or agent, who could be anyone, before the review board, in preparation for that hearing, the lawyer or agent has access to the records if the person is incapable of consenting. As of right, the person who is representing that person's interests has access to the clinical record. So there is certainly a precedent for this.

Third, I might mention in passing, there's concern about the use to which the advocate might put the information once it's in the advocate's hands. There is now case law indicating that any confidentiality attached to such things as medical records follows those records wherever they go. In other words, the advocate is under precisely the same duty of confidentiality, once granted access to the records, as the facility was under in the first place.

**Mrs Sullivan:** I think counsel has misunderstood the point, partially because perhaps she was not involved in government at the time the freedom of information provisions were being undertaken. I think those who were involved would understand the issue I am raising more extensively.

You've indicated that of course facilities will have records about patients. Yes, they will. You've indicated they could be here, there or everywhere and they could be in relation to this or that. The point is, in accessing records, the advocate should not have records other than those that he requires to conduct the advocacy services he is instructed to conduct or provide, beyond which those other records should still continue to be in the private logs of the facility. The advocate shouldn't be accessing records relating to a broad range of issues if there is one specific area for which advocacy services are required.

**Ms McKague:** I agree with you.

**Mrs Sullivan:** That's why there's the question of the need for the register. If the only filing system is the name of the patient or the person, there are going to be all sorts of records included in that file that will bear no relationship to the advocacy services needed, to which the advocate should not have the right of access. That's the point of this amendment.

**Ms McKague:** My opinion on this is that the same situation prevails in the Mental Health Act, since we've been talking about that. In fact a lawyer in certain circumstances has full access to the file. A lawyer will require only parts of that file in most cases and he may request only portions of the file.

In some cases, however, especially if the file is a somewhat disorganized and chaotic one, it may not be possible for the advocate to know in advance what portions he may require and it may therefore be necessary for him to have access to the whole file in order to determine that.

**Mrs Sullivan:** That's precisely the point of the amendment. The advocate should not have the right of access to the entire file if a portion of that file bears no relationship to the advocacy services that are being pro-

vided. That is precisely the point. The separation decision should be made by an independent organization that has the expertise, such as the Consent and Capacity Review Board, to determine which portions of the entire file apply to the advocacy services that are being performed on behalf of the person.

1720

**Ms McKague:** One last comment: If the individual, the vulnerable person, has in fact consented to the release of the file, there should be no issue at all. I would suggest your concern may relate only to the uninstructed advocacy situation.

**Mrs Sullivan:** Well, I think it relates to both. The consent from a capable, vulnerable person relates to the portions of the record about which instructions have been provided to the advocate and requests made for advocacy services. For the incapable person, the emphasis is even greater with respect to the issues that have been raised.

**Ms McKague:** So you're suggesting then that even though the vulnerable person knowingly, willingly has consented to full disclosure, it should still be in the discretion of the facility to withhold.

**Mrs Sullivan:** The vulnerable person is consenting to access records for the purpose of the provision of advocacy services in specific areas. I think we have, by example, in an informal conversation last night discussed difficulties that a vulnerable person may have in a group home. They may be interpersonal difficulties, where the services of an advocate will be of some use in assisting the vulnerable person in that home to achieve things that the vulnerable person could not achieve otherwise in terms of rights or in terms of correcting misunderstandings or improving services or whatever.

If records related to the involvement of that person were needed, surely the advocate should have only records that relate to the services for which help was requested; not to all records which may be contained but to the specific records which will help the advocate in the specific circumstance in which instructions were given.

**Ms McKague:** Might I suggest that the appropriate procedure in that case would be for the advocate to seek and receive a limited consent from the vulnerable person to say, "All we need is the information about this particular issue," and have a consent from the vulnerable person to access only that information.

**Mr Jim Wilson:** The concern being expressed by Mrs Sullivan is of course reflected in the PC motion on 24.1 also, that is, with regard to patient-specific or vulnerable person-specific records. Now you can't blame us for having a concern here when we see a government amendment dealing with 25.1 where not only do you now want access to a vulnerable person's clinical record, but you are now bringing in an amendment that would give the advocate access to documents of general application. So our antennae went up, and I think it proves the case.

The very fact that you have another amendment coming in here to broaden the access proves that our suspicion is probably correct. For the world of me, having seen the tenacity and the eagerness some of our witnesses had for



this section, I cannot help but be suspicious and fearful that, if we don't do something to make sure that there's a very stringent limitation on the extent of information that's able to be obtained pertaining to the vulnerable person, patient-specific records will be used to advance the cause of systemic advocacy.

If we're not very careful and very specific on section 24, I can think of scenarios where information pertinent to an individual could very well be used as an example of the need for systemic advocacy. I assume then the advocate communicates with more than just the people listed in the act here in terms of dealing with the government and dealing with legislators.

There's a real need for the control of access and the control of this information. I am not satisfied with what's in the act. You can't blame us for being worried about this when you've tabled a motion regarding section 25.1, where you want documents of general application. So let's come clean here, folks.

**The Vice-Chair:** Any further comments or questions? Seeing none, all those in favour of the Liberal motion?

**Mrs Sullivan:** A recorded vote, please.

The committee divided on Mrs Sullivan's motion, which was negated on the following vote:

#### Ayes-3

Cleary, Sullivan, Wilson (Simcoe West).

#### Nays-5

Carter, Malkowski, Owens, Wessinger, Winninger.

**The Vice-Chair:** We will move on to the PC motion on section 24.1. Mr Wilson.

**Mr Jim Wilson:** I won't belabour the point that we've just made regarding the Liberal motion on section 24.1, except to add, as outlined in the motion, that no record should be accessed without the consent of the facility or the controlled-access residence or program prescribed by the regulations, unless authorized by a body independent of the commission—in the case of this amendment, preferably the judiciary by way of warrant in advance—and that advocates are not entitled to access records relating to other persons. This is certainly our firm belief. Otherwise, the motion is self-explanatory.

I regret that the government has not participated with any real level of enthusiasm for about the last half-hour with regard to our concerns dealing with access to records. It's probably futile to try to argue with a brick wall, as it were.

**Mr Malkowski:** The government will not be supporting the PC motion for the following reason: The necessity to obtain a warrant is unreasonable and in fact can cause excessive delays; safeguards already do exist to protect the privacy of persons, other than the vulnerable person.

**Mr Jim Wilson:** We're ready to vote on this. I'd ask for a recorded vote.

**The Vice-Chair:** Any further comments or questions? Seeing none, we will vote on the PC motion.

The committee divided on Mr Jim Wilson's motion, which was negated on the following vote:

#### Ayes-3

Cleary, Sullivan, Wilson (Simcoe West).

#### Nays-5

Carter, Malkowski, Owens, Wessinger, Winninger.

**The Vice-Chair:** We will move on to the PC amendment to subsection 25(2.1).

**Mr Jim Wilson:** Briefly, the rationale behind this amendment is that we feel there are very few safeguards regarding the wide access to various kinds of records, such as notice, the requirement of independent scrutiny of the need for such records or the right of the facility organization to challenge the decision, particularly the latter part. We feel very strongly about the right of the operator of the facility, the residence or program to be entitled to refuse to give the advocate access to records if the advocate does not have a warrant.

Having said that, and having spent considerable time arguing along the lines as delineated in this motion, I don't expect the government's going to support it.

1730

**Mr Malkowski:** The government will not be supporting the motion. The need for a warrant is in fact unreasonable. The commission may not be able to get the reasonable grounds this section requires. In fact, we trust the judgement of the commission in providing consent to such access in this area.

**Mr Jim Wilson:** Thank you, Mr Malkowski, but our real concern here is that in an unprecedented nature the government is setting up an arm's-length commission with a built-in bias, and now you won't even let us have a check on that. If there turns out to be a witchhunt commissioned or sanctioned by the commission, there's no check on that.

Given the built-in bias of the commission, I envision very few times when a request for access to records will be turned down, because the overall inclination will be: "Go for it. When it comes to facilities and controlled-access residences and the programs prescribed in the regulation and the people running all these things, our bias is that we don't trust them." That's the thrust of this act; we're setting up an adversarial situation and "We don't trust them."

Now you won't even give us a check on that tremendous power the commission has. I don't understand that, I don't like it, and I wish you'd reconsider your position, because it is unprecedented.

**Mrs Sullivan:** We won't be supporting this amendment, but we certainly are concerned about many of the issues the amendment points to: the suspicion of facility abuse; the suspicion of abuse in every controlled-access residence and so on; the lack of process included in the act and no indication of regulations with respect to the conveying of information to the facility with respect to the requirements; charges of abuse that have been made about the facility or the residence or the program. Once again, what we see is, in the case of people providing service from the facility side, no redress or due process.

We feel that an adversarial situation has been set up through this act in all cases, rather than a process through which there can be a compromise through which information can be conveyed that will enhance improvement. We know there are powers for action to take place when there is abuse. There is, however, no right for record correction or even information to the facility or program or residence when charges or suspicions are held. Even under the inspection process, by example, of the Nursing Homes Act there are discussions that take place, under the child care act there are discussions that take place, and indeed improvements can be made.

In this case, the relationship that is implied through this legislation is an adversarial one between the providers on the one side and the advocates on the other. I'm convinced the warrant is the appropriate way to go, which is why, by example, on the previous amendment on records we went a different route. But we feel that the adversarial nature here is just inadequate.

**Mr Jim Wilson:** I would ask members to look at subsection 25(2). If you read that section, it's the criteria the commission must use in determining whether it's going to give consent to an advocate for access to the records. Read this 25(2). If that isn't a green light to go and seek whatever records you want, I don't know what is. Anybody could make a case that the purpose is "detecting or demonstrating the existence of systemic policies or practices that may be detrimental to vulnerable persons." Those are very weak criteria any way you look at it.

All we're asking for are some safeguards with respect to the consent that can be given the commission, given the bias of the commission and given that it doesn't even have to make what I would consider really a case. I think it's disturbing that Mr Malkowski pointed out that he didn't feel the commission could meet a "reasonable grounds" test. You're dealing with people's records and privacy and you're giving tremendous powers to a biased commission, and then you're saying to that commission, "Well, for semantic purposes, we have to have some criteria in this act." But as to the criteria, you can drive a bloody truck through that paragraph. It doesn't mean anything.

You wouldn't even, as a schoolteacher, assign a student to write an essay using those criteria as the parameters to come up with the body of an essay. I mean, it's just ridiculous. I'll bet every witness who appeared before us during the public hearings could meet those criteria in terms of making a case for the need to access those records. There are no teeth in this, so why do you even have it in the act?

All we're saying is that if you're going to have it in the act, there should be some safeguards. Maybe you don't want to do the warrant. Maybe we should stand this down and try and come up with another set of safeguards over dinner, but there must be safeguards.

**Mr Malkowski:** I think Mr Wilson misunderstood my point. I'll just ask the political adviser to clarify that issue.

**Ms Valentine:** I'm not sure what Hansard will show. I think what was inferred was that sometimes it's necessary to have the access to be able to gain enough concrete information to show the reasonable grounds.

Again, it's not a situation of someone initiating an activity of systemic advocacy without some reason to do so in the first place, but often in order to develop enough information to be able to concretely show where a change is needed or what the problems are, where abuse exists. Whatever the situation is, it is necessary to have access to be able to gather some factual information, rather than subjective information, information being told by patients but without being able to have information from the records to verify it.

**The Chair:** Further discussion? Seeing none, we'll now call the vote on the PC motion on subsections 25(2.1) to (2.3).

**Mr Jim Wilson:** We should have a recorded vote. It should be only one name.

The committee divided on Mr Jim Wilson's motion, which was negated on the following vote:

#### Ayes-1

Wilson (Simcoe West).

#### Nays-7

Brown, Carter, Cleary, Malkowski, Morrow, Wessinger, Winninger.

**The Chair:** We will now go to the government motion on section 25.1. Any comments?

**Mr Jim Wilson:** There are a lot of comments on 25.1. I know my Liberal colleague Mrs Sullivan has some very strong feelings about this. With the indulgence of the committee, we could either recess for five minutes till she returns or—actually, that would be the fairest thing, I think.

**The Chair:** This committee will stand recessed for five minutes.

The committee recessed at 1741.

1754

**The Chair:** I call this committee back to order. Mr Wilson.

**Mr Jim Wilson:** I would like to begin the discussion on the government motion dealing with section 25.1 by asking exactly what is intended and meant by "document of general application" in the motion.

**The Chair:** Could you please repeat that?

**Mr Jim Wilson:** The motion reads, in part, "to any record that is a document of general application relating to the observation, care, treatment or management of persons that is in the custody or control of," and it lists "a facility" etc. I just want to know what is meant and intended by "document of general application." What types of documents can be accessed under this power?

**Mr Malkowski:** I would like to just refer that to our policy adviser for clarification.

**Ms Valentine:** It would be generally the same type of record, whatever type of record is kept about a resident patient. It actually, from the best of our understanding, was probably an error in the original drafting. It really is only bringing the issue consistent with access in other facilities. Again, there's a bit of a fallacy in having access to the



facility but not to the record in order to be able to carry out advocacy.

**Mr Jim Wilson:** Which records, though? I think this amendment refers specifically to what we heard from the advocacy coalition with regard to policy manuals, etc. I'm just sort of wondering if that's right and, secondly, what type of documentation is envisioned.

**Ms Valentine:** Am I on the right amendment, 25.1? I'm sorry; I just came back in.

**Mr Jim Wilson:** Yes.

**Ms Valentine:** As far as any record of general application, yes, it's the type of information that would normally be available under freedom of information if it's a government-run facility, but if it's not a government-run facility, then general policy guidelines, general operational manuals, policy and restraints procedures, all of those sorts of things.

Perhaps I could go back to the restraints issue that's been mentioned from time to time. Clearly, there are times when restraints are used in facilities, but they need to be used with particular safeguards, with particular guidelines. There are particular requirements for people only being kept in restraints for a certain period of time before they're checked, and they have to be observed in a certain way and so on. Without access to that type of standard or guideline within the facility, it's difficult for the advocate to know how to go about even beginning to assess information as to what's happening.

**Mr Jim Wilson:** Would there be anyone available in the room to let us know the thoughts of the Legislature at the time it exempted these facilities under FOI and the reasons why?

**Ms Valentine:** FOI doesn't cover such facilities. It is government-run facilities that FOI covers.

**Mr Jim Wilson:** And there's no extension to facilities that receive government funding such as these. Okay.

**Mrs Sullivan:** I think we'll be voting against this motion because of the lack of clarity in the motion. The indication of records of "general application relating to observation, care, treatment or management of persons" is by itself so broad and so extensive that the concept is a frightening one.

The misunderstandings that can be created by this particular amendment, it seems to me, are very extensive. I was interested today in seeing comments from the Minister of Citizenship with respect to new federal immigration policies indicating that she was extremely concerned that immigration regulations would be made away from the public eye and therefore without public understanding and involvement in those decisions. You know that we have had the same concerns about regulations being made under these bills. In fact, in this case there isn't a regulation and there is no understanding of the specific nature of the kinds of records. The word "record" is used in this motion, not "document," which is a different thing. A "policy manual" is a very different publication than a "record." We just feel that, as it's worded and as it's presented, there are

frightening implications to this particular government amendment.

**Mr Malkowski:** Just to respond—actually, I'd like to refer that to our policy analyst to respond to that concern.

1800

**Ms Valentine:** I'm not really sure I have much more to add, other than to say that we went with the policy intent of the legislative counsel and this was the suggested wording. The intent, as I say, is largely to the same types of documents and so on that are provided under FOI. Government facilities are available under FOI, and government facilities are considered generally available to any member of the public.

**Mrs Sullivan:** Would the government consider then standing this down and redrafting so that this particular motion could be considered latterly with more specific information that would lead to less misunderstanding? I think that might be a useful way of dealing with this. We certainly cannot support this in its current form because of the breadth of information that's provided for in this amendment. If the government's intention is specific with relation, by example, to employment policies or codes of ethics or procedures within an institution or a place, the FOI does spell those things out. I think we should have a similar provision in this bill and we would prepared to consider it, but in its current form we simply cannot support this. It's way beyond what we could possibly accept.

**Mr Malkowski:** I do appreciate the concerns you've raised and we will be amenable to that. We'll stand down the motion.

**The Chair:** Do we have unanimous consent to stand this government motion, 25.1, down? Agreed?

**Mr Malkowski:** I now move that we adjourn the committee for the day.

**Mrs Sullivan:** Mr Chairman, we would like—

**The Chair:** This is nondebatable.

**Mrs Sullivan:** Frankly, I don't give a damn if it's not debatable. I want to speak to this and it's my right to speak to it.

**The Chair:** There is no debate on a motion to adjourn.

**Mrs Sullivan:** Then I want to raise a point of order.

**The Chair:** On a point of order?

**Mrs Sullivan:** Thank you. The government yesterday stood down several motions that were put by the opposition under the guise of having to receive consultation. We sat until 10:30 last night debating issues that were very important and that have not had that kind of debate. We are quite prepared to sit again tonight so that some of the other very important issues that have been put forward in amendment can receive appropriate debate.

We believe that the attitude of the government with respect to Bill 74 to date has been pretty darned irresponsible. I've indicated before today in our discussions that through the public hearings, because of the time allocation, we had inadequately explored many of the issues that are associated with this bill.

The opposition parties are prepared to take a break for dinner and return tonight. We believe that the issues here are matters of grave, important public concern. This is new law. This is not a collective bargaining situation, as I indicated to the staff person from the Minister of Citizenship last night. We want to talk about these issues.

We feel, as opposition, that we have contributed in terms of the development of policies on this and other bills. We know that on Bill 108, by example, we probably won't have to take the entire one and a half days, or at least we expect that, or certainly will not have to go later than 5 o'clock. We seem to be reaching an accommodation on that bill.

We have explored, in discussion, many of these issues. We have yet to hear the government's response on issues which, at the government's request, were stood down, and we would like to come back at this and complete this bill tonight.

**The Chair:** I can understand your concern, but you do not have a point of order, Mrs Sullivan.

**Mr Jim Wilson:** I have a true point of order, Mr Chairman. In light of the orders that came from the House, I don't think this motion can be accepted and voted on at this time. We were ordered and allowed two full days. The day ends at midnight. You cannot shut down debate on this bill, because of the orders from the House. You cannot accept that, and I'll ask the Speaker for a ruling on that if I have to. You cannot accept that, because two full days have not expired on each piece of legislation. You can't just shut it down because somebody asked for what is a non-debatable motion. I don't think you can accept that in order, Mr Chairman. That is not in order, and for you to rule otherwise flies in the face of the orders given by the Legislature. I do not think that's stretching it at all.

**The Chair:** I agree you do have a point, but a motion to adjourn is always in order.

**Mr Jim Wilson:** It is in terms of Robert's Rules of Order, but I would think we're dealing with rules that take precedence over that—that is, orders from the Legislature, which is supreme. Regardless of what Robert's Rules or the standing orders of this committee would be, the Legislature has ordered us and given us the right to spend two full days, and the day ends at midnight.

**Mrs Sullivan:** Mr Chairman, can I ask for unanimous consent for that motion to be rescinded?

**The Chair:** Do we have unanimous consent? No, we don't have unanimous consent.

**Mrs Sullivan:** Could we have some explanation?

**The Chair:** Could we have a two-minute recess, please?

The committee recessed at 1806.

1809

**The Chair:** I call this meeting back to order. First of all, in response to Mr Wilson, while the House is sitting, it's true the committees do adjourn at six o'clock. When the House is not sitting, we are free to sit till midnight, but a day is very loosely interpreted. I know there was a discussion last night about whether we had our two days in, as we had sat Monday afternoon, Tuesday morning, Tuesday afternoon and then Tuesday evening. So it would have been questionable whether we had our two full days in, but as we have gone this afternoon also, I would say we have gone the two full days.

A motion to adjourn is always in order.

**Mrs Sullivan:** On a point of order, Mr Chairman: One of the things I wanted very much to have on the record and to request of the government is related to some of the debate with respect to the subsections that were debated earlier today and the concern that indeed we might be passing legislation that would infringe the Charter of Rights and Freedoms.

I want to ask the committee if it would ask the Attorney General to make a reference to the appeal court to determine if the subsections with respect to access to residences were appropriate.

**Mr Mark Morrow (Wentworth East):** On a point of order, Mr Chairman: The point of order the honourable member is referring to is not a point of order, is it?

**The Chair:** You're right. She did not call for a point of order; she was just making a statement. Maybe it would be more appropriate tomorrow morning.

One suggestion to the committee though, possibly, is that as we still have a fair bit to go on Bill 74, it might be possible for the government staff and the opposition staff to sit down and see if they can't work things out, because the amendments are still available to come in.

We'll now go to the vote on the motion to adjourn.

**Mrs Sullivan:** A recorded vote, please.

The committee divided on Mr Malkowski's motion, which was agreed to on the following vote:

**Ayes—6**

Carter, Malkowski, Morrow, Owens, Wessinger, Wininger.

**Nays—4**

Brown, Cleary, Sullivan, Wilson (Simcoe West).

**The Chair:** This committee stands adjourned until 10 tomorrow morning.

The committee adjourned at 1812.



## CONTENTS

Wednesday 2 September 1992

Substitute Decisions Act, 1992 . . . . .	J-351
Advocacy Act, 1992 . . . . .	J-358

### STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

- \*Chair / Président: Cooper, Mike (Kitchener-Wilmot ND)
- \*Vice-Chair / Vice-Président: Morrow, Mark (Wentworth East/-Est ND)
  - Akande, Zanana L. (St Andrew-St Patrick ND)
- \*Carter, Jenny (Peterborough ND)
- Chiarelli, Robert (Ottawa West/-Ouest L)
- Curling, Alvin (Scarborough North/-Nord L)
- Harnick, Charles (Willowdale PC)
- Mahoney, Steven W. (Mississauga West/-Ouest L)
- \*Malkowski, Gary (York East/-Est ND)
- Runciman, Robert W. (Leeds-Grenville PC)
- \*Wessinger, Paul (Simcoe Centre ND)
- \*Winninger, David (London South/-Sud ND)

#### Substitutions / Membres remplaçants:

- \*Brown, Michael A. (Algoma-Manitoulin L) for Mr Mahoney
- \*Cleary, John C. (Cornwall L) for Mr Curling
- \*Owens, Stephen (Scarborough Centre ND) for Ms Akande
- \*Sterling, Norman W. (Carleton PC) for Mr Harnick
- \*Sullivan, Barbara (Halton Centre L) for Mr Chiarelli
- \*Wilson, Jim (Simcoe West/-Ouest PC) for Mr Runciman

\*In attendance / présents

#### Also taking part / Autres participants et participantes:

Fram, Steve, counsel, policy development division, Ministry of the Attorney General  
Malkowski, Gary, parliamentary assistant to the Minister of Citizenship  
McKague, Carla, counsel, Office for Disability Issues, Ministry of Citizenship  
Perlis, Linda, policy analyst, Office for Disability Issues, Ministry of Citizenship  
Valentine, Mary Beth, senior policy and program adviser, Office for Disability Issues, Ministry of Citizenship  
Winninger, David, parliamentary assistant to the Attorney General

Clerk / Greffière: Freedman, Lisa

#### Staff / Personnel:

Filion, Sibylle, legislative counsel  
Hopkins, Laura, legislative counsel



## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Thursday 3 September 1992

### Standing committee on administration of justice

Substitute Decisions Act, 1992

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Jeudi 3 septembre 1992

### Comité permanent de l'administration de la justice

Loi de 1992 sur la prise de  
décisions au nom d'autrui

Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
Greffière : Lisa Freedman





### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

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La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Thursday 3 September 1992

The committee met at 1018 in committee room 1.

### SUBSTITUTE DECISIONS ACT, 1992 LOI DE 1992 SUR LA PRISE DE DÉCISIONS AU NOM D'AUTRUI

Consideration of Bill 108, An Act to provide for the making of Decisions on behalf of Adults concerning the Management of their Property and concerning their Personal Care / Loi prévoyant la prise de décisions au nom d'adultes en ce qui concerne la gestion de leurs biens et le soin de leur personne.

**The Chair (Mr Mike Cooper):** I'd like to call this meeting of the standing committee on administration of justice to order. We'll be continuing our clause-by-clause examination of Bill 108. Mrs Sullivan, when you were interrupted last evening before we adjourned, you were making a statement. Would you care to proceed with that?

**Mrs Barbara Sullivan (Halton Centre):** Thank you, Mr Chairman. We had been cut off and I intend to put a motion forward as an amendment to the bill, which will in fact meet the point I was raising. That amendment will in fact indicate that section 17 of the bill should not come into force until a reference to the appeal court has been requested by the government to determine the constitutionality of that section and the appeal court has reported its decision in the matter.

I've decided to put this forward as an amendment because under the rules of this committee, even if it can't be considered in the discussion, it will be deemed moved and as a consequence will be part of the record relating to the committee, will be brought to the attention of the Legislature and hence the public. So that's the way I intend to proceed in that area.

**The Chair:** All right. As long as you have that in before September 15, that will be quite in order.

**Mrs Sullivan:** It will be there.

**The Chair:** Thank you very much. We'll now continue where we left off, on the Liberal motion 10(3) and (4). Sorry, that was withdrawn.

Okay, next we go to government reprint 10.1. Comments?

**Mr Paul Wessenger (Simcoe Centre):** I thought there might be some amendment to that.

**Mrs Sullivan:** Yes. It's coming, Mr Chair.

**Mr Wessenger:** So we should not deal with it until we—

**The Chair:** Okay. Just a moment.

Mrs Sullivan moves that subsections 10(1) and (2) of the bill, as reprinted to show the amendments proposed by the Attorney General, be struck out and the following substituted:

"Execution

"(1) A continuing power of attorney shall be executed in the presence of two witnesses in the manner described in subsection (4).

"Persons who shall not be witnesses

"(2) The following persons shall not be witnesses:

"1. The attorney or the attorney's spouse or partner.

"2. The grantor's spouse or partner.

"3. A child of the grantor or a person whom the grantor has demonstrated a settled intention to treat as his or her child.

"4. A person whose property is under guardianship or who has a guardian of the person.

"5. A person who is less than eighteen years old."

**Mrs Sullivan:** This amendment really combines the amendment I put forward yesterday and Mr Sterling's amendment, which he put forward, and comes forward as a result of the discussion that ensued with respect to the amendments which we have put on the table on the question of who should qualify to be a witness.

**The Chair:** Could you withdraw your other motion on 10(2)?

**Mrs Sullivan:** I will withdraw the Liberal motion 10(2).

**The Chair:** Okay. All those in favour of the Liberal motion on subsections 10(1) and (2)? Opposed?

Motion agreed to.

**The Chair:** Okay, we'll go to the government reprint on 10(3), (4) and (5).

**Mrs Sullivan:** Mr Chairman, I think we are supposed to have an amendment to 10(4).

**Mr Wessenger:** I believe we passed that, didn't we?

**Mrs Sullivan:** Did we?

**Mr Wessenger:** And we deleted (3), if I remember correctly.

**Mr Sterling:** That's right.

**Mr Wessenger:** We should be just dealing with (4).

**Mr David Winninger (London South):** We passed 10(3).

**Mr Norman W. Sterling (Carleton):** We passed a motion to exclude the part contained on page 8 of the reprint, that is, the words, "and at the same time make a written statement in the prescribed form."

**Mrs Sullivan:** We haven't passed that.

**Mr Sterling:** Yes, we did.

**Mrs Sullivan:** Okay.

**The Chair:** Subsection 10(3) was passed.

**Mr Winninger:** Subsection 10(3) was voted on.

**The Chair:** And passed.

**Mrs Sullivan:** Sorry. I just didn't write it down.



**Mr Winninger:** The issue was whether 10(4) was passed in its amended form.

**The Chair:** Government reprint 10(5). Comments? Carried.

Government reprint 10.1. Discussion? Carried.

Next, government reprint, clause 11(1)(a). Carried.

Mr Sterling moves that subsection 11(1) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended and the following added:

"11(1)(c.2) unless the grantor provides that there shall be multiple continuing powers of attorney."

**Mr Winninger:** We're agreeing to that amendment, but there needs to be a slight change in the numbering. This is in accordance with the Canadian Bar Association recommendation, but we feel it should be clause 11(1)(c.1), because it's an addition to what is in our reprinted act as (c.1). There is no (c.2). That's all.

**Mr Sterling:** Yes, that's right. I will withdraw the previous motion.

I move that subsection 11(1) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended and the following added:

"11(1)(c.1) unless the grantor provides that there shall be multiple continuing powers of attorney."

**Mr Winninger:** That's acceptable. Could we stand it down while it's being rewritten?

**Mr Sterling:** Pourquoi?

**Mr Winninger:** Because legislative counsel just requested it.

**Mr Sterling:** She's got a copy of it right now.

**Mr Winninger:** Pourquoi pas?

**Mr Sterling:** It doesn't need a lot of discussion. There was a concern that the way section 11 was drafted, it would exclude multiple continuing powers of attorney, which means that a grantor would grant to two or three or four or more people the power of attorney. Often a parent does that with regard to his children, in case one child is unable or unwilling to act as the attorney. All this does is make it clear that it is possible to create a multiple continuing power of attorney. It's more a point of clarification than anything else, Mr Chairman.

**The Chair:** Thank you. Further discussion? Seeing none, all those in favour? Opposed? Carried.

Mr Sterling, could you read your last one into the record, please? Withdraw what you had and re-read.

**Mr Sterling:** I am asked to withdraw and I agree to withdraw.

**The Chair:** Mr Sterling moves that subsection 11(1) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended and the following added at the end:

"11(1)(c.1) unless the grantor provides that there shall be multiple continuing powers of attorney."

Motion agreed to.

1030

**Mr Sterling:** I have a difficult time, Mr Chairman, getting these motions straight.

**The Chair:** I can understand that. Nothing personal, of course.

Next we will go to the government reprint, in the French version, subsection 12(1). This is only in the French version. Discussion? All those in favour? Carried.

Next, the government reprint, section 14. We'll need unanimous consent to have this one moved. Government reprint 14. All those in favour? Opposed? Carried.

Next, the government reprint, subsections 17(3) and (3.1). Discussion? Carried.

Government reprint, subsection 17(4.1). Mr Sterling?

**Mr Sterling:** Can I just ask some questions in this whole area? We have an application being made. One of the amendments that were put forward by the Canadian Bar Association which I didn't include was the notion of whether it was an application or a notification to the official guardian or the public guardian and trustee. When a person has a continuing power of attorney, it was felt by the bar association that it's not an application in the sense that really, you're telling them that you have it.

The other part is, is there any kind of obligation on the public guardian and trustee to accept the application? How does he or she do that, and is there any kind of time limitation on them to do that?

**Mr Winninger:** Mr Chair, perhaps we could hear from counsel on that.

**Mr Steve Fram:** What we have is an application. Under the existing law, when somebody is certified under the Mental Health Act, in order to continue operating under the power of attorney, he presents a copy of the power of attorney to the public guardian and trustee.

In response to the Canadian Bar Association's first submission, we altered the provisions to essentially recreate the same type of process whereby the person applies to be a statutory guardian. Being a statutory guardian has certain advantages: He can prove it to third parties; third parties can't look behind it to the principle. Therefore, it's advantageous in terms of administering the property.

So we've got rid of all the requirements except that they apply, present a certified copy of the power of attorney under the provision. They're undertaking to act under it, which is the key important thing for the public guardian and trustee, because he wants to know that somebody is going to be acting. There are powers of attorney that exist, but a power of attorney by itself doesn't oblige the person who is the attorney to act, so this undertaking is given.

Then under clause 17(7)(b), the public guardian and trustee does not have any discretion but must issue a certificate. Then we get to subsection 17(7.1): "The certificate is proof of the guardian's authority." So the process approximates the existing process without giving discretion to the public guardian and trustee.

**Mr Sterling:** My greatest concern is the time factor. I'm thinking of an accident where the grantor of the power of attorney goes into a coma and the next day there's a requirement to close, say, a real estate transaction. The power of attorney is going to have to step in and sign the final paper. Is the power of attorney still good? Does he need the guardian's—

**Mr Fram:** There's a straightforward answer. In the case that you've posed, the attorney would continue to act. The only time this comes up at all is when there has been either certification under the Mental Health Act that somebody is incapable of managing his property or if there has been certification by an assessor, which would only be requested if there was a problem.

Most of the time, people will just rely on their attorney, as they do now, and there will not be any reason for the attorney to become a statutory guardian. In the case you've posed where somebody has a heart attack or is in a coma or is injured or is in hospital, if there is somebody to manage the property, nobody's going to go to the—

**Mr Sterling:** Somehow I had the impression it was obligatory and it's not. That's fine.

**The Chair:** Further discussion? Being none, we'll move to the vote. All those in favour? Carried.

We'll move on to the Liberal motion on subsection 17(5).

Mrs Sullivan moves that subsection 17(5) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by striking out "by an applicant described in subsection (2) or" in the first and second lines.

**Mrs Sullivan:** This amendment would delete the requirement that family members must provide evidence of security for the value of property in making an application for guardianship.

1040

**Mr Winninger:** We have a problem with that. These are people, named in subsection (2), who were never chosen by the incapable person. We feel under these circumstances that it's important that security be posted, but we are also mindful that subsection (6) permits a court to dispense with security.

That regime is similar to the one that prevails with an administrator of an estate, who is normally expected, even a family member or a friend, to post a bond, but that can be dispensed with depending on the circumstances. If you've got a \$5,000 estate, you're not going to require a \$1,000 premium for a bond, so it makes perfect sense, given subsection (6), to retain the section, as the government has done, and not to amend it as suggested in the Liberal motion.

**Mrs Sullivan:** I think it's an onerous duty on a spouse or a child who is seeking guardianship of a person who has been certified or where an assessor has indicated that there's an incapability. Accepting the guardianship as part of the family, and particularly I think of the spouse or child, already brings with it onerous duties with respect to the management of that property. In the spouse's case in particular, there already is a partnership, if you will, in terms of the assets under the Family Law Reform Act. That's clear.

I'm really quite concerned about an additional requirement that a spouse has to post a bond in relationship to the guardianship of an incapable spouse. Similarly, if a child is in the situation where quite onerous duties in terms of guardianship are being taken on with respect to an incapa-

ble parent, once again the obligation of posting a bond as evidence of security seems to me to be an unfair one.

**Mr Wessinger:** I'd just like some clarification. Under the Mental Incompetency Act at present, is there a requirement that a bond be posted?

**Mr Winninger:** I can answer that as well. There is a requirement, but it can be dispensed with.

**Mr Wessinger:** And it also can be dispensed with. So basically we're not changing the existing law.

Am I also correct that if the consent of all of the potential beneficiaries was obtained, the requirement of the bond would likely be dispensed with?

**Mr Winninger:** That's right.

**Mr Wessinger:** Okay.

**Mr Winninger:** I don't mind saying I had one case like that where a daughter became the committee of her aged mother who had Alzheimer's. In that case, it seemed onerous that the daughter should have to place a bond and pay insurance premiums on a bond, so that was waived, by the court, though.

**Mrs Sullivan:** How long does it take for a court to waive that obligation? In the interim period, does the bond not have to be posted?

**Mr Winninger:** In the present legislation, as part of the incompetency order appointing the committee, there will be a provision dispensing with the bond.

**Mrs Sullivan:** But these are different. Basically this says you must post the bond, and then the court may later, if applied to, relieve you from that bond. So in fact you have to go through the process of providing evidence of security, which means having the bond.

**Mr Winninger:** I think it is important to ensure that there's meaning to the accountability that has to be exercised, and if there are virtually unfettered powers over the property of the incapable person, there has to be some safeguard there in case decisions are made that might tend to dissipate the property. I think it should be the exception rather than the rule that a bond is dispensed with.

**Mrs Sullivan:** Is what is included here, then, precisely as it is in the Mental Incompetency Act? You've indicated, by example, that the requirement for security under that act is waived before the application, or while the application itself is being considered. In this case, it's a two-step process, according to this wording. You must have evidence of the security, which means that you must already have purchased the bond, and only latterly can the court waive that. That is not the case now, as I understand it.

**Mr Winninger:** Could I also say that this section does give latitude to the public guardian and trustee as to evidence that the applicant is able to provide security. It says "in a form...approved by the public guardian and trustee." Maybe I can let counsel speak to this as well.

**Mr Fram:** The provision does not give the public guardian and trustee the ability to choose whether or not there should be security. So the rule is security unless the court waives it, because in fact giving that kind of discretion to the public guardian and trustee is administratively



unwise. He then has to choose between the people he can trust and the persons he can't, and that is a very difficult role, a kind of choice that we usually reserve to the court.

Under the Mental Incompetency Act—this process dispenses with the need to prove that the person is incapable. It's really an application to dispense with security, that part of the application itself. As pointed out, it isn't someone who's taking over the management of property and who has been chosen by the person—they don't have to pose security. It's only as a result of this list that we put in the legislation that this takes place, and that the person himself or herself never chose to have an attorney.

So it was felt quite important to put in that provision, because, after all, it's the welfare of the person who is incapable that we're really concerned about, primarily.

**Mr Sterling:** Could I just ask sort of a supplementary question on this? If we can avoid making the process more complicated from both points of view—that is, for members of the family and for the public guardian and trustee—was there any consideration in this to putting some kind of minimal-upset limit? I think a lot of the people we would be talking about here would have very few assets. Therefore, would it be or has it been considered that no security would be necessary if the total assets were less than \$3,000?

**Mr Winninger:** Mr Chair, I'd like a moment to confer with counsel here, but I would think that the amount of assets is entirely independent of whether a person is incapable or not. Someone with Alzheimer's, for example, could have spent a whole lifetime amassing assets.

**Mr Sterling:** No, no. Then, I think, security is important.

**Mr Winninger:** Right.

**Mr Sterling:** But what I'm saying is that, for instance, when we talked about the people with schizophrenia, many of them, from the evidence we heard here or from the parents of those people—we heard about people who were on the street, not that great. I guess what I'm saying is, by putting an upset limit there, be it \$3,000 or whatever, the gamble isn't that great.

**Mr Winninger:** Could I confer with counsel for a minute? It's a matter of interpretation.

**Mr Wessinger:** Before you do, I think we should stand this down. Maybe we need a recess to look at the matter, because I'm concerned about the multiplicity of proceedings, and maybe a simple amendment could still keep the intent of the legislation. So if we could just have a five-minute recess.

**The Chair:** This committee will have a five-minute recess.

The committee recessed at 1053.

1112

**The Chair:** I call this committee back to order. It's my understanding that they're getting a redraft right now, so with unanimous consent we'll stand down the Liberal motion on 17(5). Agreed? Agreed.

We now go to the government reprint on 17(7.1). Comments?

**Mr Sterling:** I have an amendment that I want to put forward to 17(7). I haven't got it copied yet, but I can read it.

**The Chair:** Mr Sterling moves that section 17 of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by adding the following subsection:

"17(7.2) The public guardian and trustee shall either give or refuse a certificate appointing the applicant as the incapable person's statutory guardian of property under clause 17(7)(b) within 30 days after receiving the attorney's application unless there is some question as to the grantor's capacity."

Perhaps we can get a copy of that.

**Mr Winninger:** We'd like to consider that amendment and ask that it be stood down.

**Mr Sterling:** Fine. I agree.

**The Chair:** Do we have unanimous consent? Agreed.

**Mr Wessinger:** Do we need to stand down the rest or not? Does it have any effect on 17(7) or (7.1)?

**The Chair:** I don't believe so. We go to government reprint, subsection 17(9). Comments? Carried.

Government reprint, subsection 24(2).

**Mr Winninger:** We deleted there.

**The Chair:** Carried? Carried.

Government reprint, subsections 24(3.1) and (3.2). Carried? Carried.

**Mr Sterling:** How come you guys always follow what happens up here?

**Mr Winninger:** Half the time I'm following.

**The Chair:** Next will be the government reprint, subsection 27(10). Comments?

**Mrs Sullivan:** Could I ask a question about section 26, just for clarification? I know it's not in the order, but could counsel tell us—the section reads, "The court may, on any person's application, vary an order appointing a guardian of property or substitute another person as guardian." What are the limits on "any person"? Are there any limits?

**Mr Fram:** There are no limits. Any person can apply to vary the order. Whether the court will grant it will really depend on cause being shown for the variation.

**Mrs Sullivan:** Is that the practice now? I had thought of putting an amendment forward, and I frankly didn't know enough about what the current practice is, but "any person's application" to vary an order seems to me to be extremely broad. Does it have to be that broad?

**Mr Winninger:** I don't see why you'd want to limit it. There may be people in the person's, I guess, constellation who may have an interest or concern and seek to vary. What would be the advantage of limiting it?

**Mrs Sullivan:** I suppose frivolous applications.

**Mr Winninger:** The court always reserves jurisdiction to deal with frivolous applications, frivolous and vexatious proceedings.

**Mrs Sullivan:** I just wanted that clarification. I was concerned that it was pretty broad. Thank you.

**The Chair:** All right. Government reprint, subsection 27(10). Carried? Carried.

Government reprint, subsection 31(1.1) and (2). Discussion? Carried.

Next is a PC motion, subsections 32(3) and 32(3.1).

Mr Sterling moves that subsections 32(3) and 32(3.1) of the bill, as reprinted to show the amendments proposed by the Attorney General be deleted, and replaced with the following:

“32(3) A guardian shall consult from time to time, with the incapable person on decisions about the property.”

1120

**Mr Sterling:** This results from the Canadian Bar Association's brief and also, I guess, to some degree from some personal experience I had when practising law and dealing with attorneys and people who are assisting in taking care of property.

The government's legislation as it now stands, I think, would be satisfactory if we were thinking about a guardian of property who was a close member of the family, a close friend etc, where there would be a natural instinct to be in contact with the incapable person. But in a lot of cases it doesn't work that way and the power of attorney for property is someone who is a professional manager of investments, of money, of property, of real estate etc, and in some cases, I guess, you're dealing with a larger amount of property which the guardian would be taking care of or making daily decisions about that person's property. I just wondered if the costs that are associated with being the attorney would escalate too quickly if we make the burden and terms of consultation too great.

I realize there's another side to this story too in acting as adviser to various kinds of people. I do understand that the consultation with an incapable person is important as well. But I just thought the idea of throwing the guardian in the position of, as I read it, almost having to deal with not only all of the decisions the guardian might be making on behalf of the person, but also this other part about fostering contact between the family and the incapable person, particularly when you're talking about a trust officer in a large operation, or somewhat remote from where the incapable person might be, is perhaps a burden which is too great, so I put that forward. I'm interested in hearing other people comment on it.

**Mr Winninger:** I think we have to be quite clear why these subsections 32(3) and 32(3.1) are in here. In the past, there's been considerable criticism that guardians have been too remote from the incapable people whom they're making decisions on behalf of.

I think you have to apply a reasonable test here. If the guardian, whether it's a big institution or an individual person, is making a routine bank transfer to pay for a utility or realty tax or something like that, I don't think that guardian is obliged under this section to go to the incapable person every time an administrative, routine decision is being made. On the other hand, it does place a responsibility incumbent upon the guardian to meet from time to time with the incapable person and allow that incapable person, to the best of his or her abilities, to participate.

I might add that subsection 32(3.1) actually fosters dialogue with supportive family members as well, and I'd be surprised that Mr Sterling would seek to reduce that dialogue with family members.

**Mr Sterling:** Hey, I'm not saying I'm seeking to—come on, now. That's taking a bit of liberty with what I said.

**Mr Winninger:** You're seeking to delete subsection 32(3.1), which makes reference to family members as well.

**Mr Sterling:** I'm saying the obligation of the guardian to put these people together is perhaps unreasonable.

**Mr Winninger:** Okay. Lastly, I know that large institutions like Canada Trust delegate their powers to their trust and estate officers and what have you, and I know from some experience that there is a personal relationship that often develops—

**Mr Sterling:** Oh, there is.

**Mr Winninger:** —between the trust officer and the individual whose trust is being administered, so I don't see that as being unduly problematic. I would like to see these subsections remain in there and therefore we will be opposing the PC motion.

**Mrs Sullivan:** I'm concerned about the deletion that's included in this amendment of the subsections that are there. I think, however, the point Mr Sterling raised about the duty to consult from time to time, in the instances that he raises it, is a good point. On occasion, there is no consultation; there's simply a continuing operation. While subsection 32(3) provides an obligation of the guardian to encourage the person to participate to the best of his or her abilities and decisions, it doesn't require the consultation from time to time. I am concerned about the proposal to delete the other sections.

**Mr Sterling:** Mr Chairman, I withdraw the motion.

**The Chair:** We'll now go to the government reprint, subsections 32(3.1), 32(3.2) and 32(3.3). Agreed? Agreed.

Next is a PC motion on subsection 34(2).

Mr Sterling moves that subsection 34(2) of the bill, as reprinted to show the amendments proposed by the Attorney General, be deleted.

**Mr Sterling:** Subsection 34(2), as it now reads, says, “The guardian has power to complete a transaction that the guardian entered into before the incapable person's death or the termination of the guardianship.”

I think there shouldn't be a mixture between the guardian's power to act on behalf of a person or a person's estate after he or she has died and the executor who would take over from the exact time of death or the termination of the guardian. The executor has to honour the commitments made by the previous guardian, and that is well understood, or the succeeding guardian would have to be responsible for the past guardian's commitments and obligations and contractual rights. I'm not quite sure of the reasoning behind this section, but I think it really muddies the legal situation in dealing with property rather than providing any clarification.



**Mr Winner:** I don't mean to sound cagey about this, but the motion and the amendment do have appeal to me, but we need to stand it down to check on a few considerations.

1130

**Mr Wessinger:** I would like to make a comment from the other point of view, if I could, before we stand it down. I'd just like to make the comment that I think this amendment is in here to assist in the completion of transactions. As you know, under the existing law you have to have an executor and administrator appointed in the case of the death of a person who has a power of attorney. That's the existing law and I think the purpose of this was to assist the completion of a transaction.

There could be an occasion when it would be in the estate's interest to complete the transaction. In other words, you could have a purchaser trying to get out of a deal—or a vendor, but particularly a purchaser—and this would give him the right to walk if we didn't have this provision in. So I can see the advantage of having the provision with respect to death.

**Mr Winner:** Mr Chair, we can consider both the submissions of Mr Wessinger and Mr Sterling if we're given the opportunity to stand this down.

**Mr Wessinger:** Yes, I'm happy now to have it stood down.

**Mr Sterling:** Could I just say in response that that is the case with capable people. In other words, if a capable person had entered into a contract and died, his estate faces the same problem with regard to that.

The big problem I see is, when has a transaction started and when has it completed? If you permit a guardian to control part of a deceased's estate past the date of death, he may, if mischievous, claim that he's in the middle of a whole bunch of negotiations dealing with property asset A, D, M, N, L and P and that the executor can take over the other parts of the estate.

I think it's better if you have a clear demarcation. Lawyers and executors have dealt for centuries with the problem of death occurring in an untimely way with transactions that are in place, and there are ways of passing letters probate relatively quickly in order to obtain the necessary authorization.

**Mr Wessinger:** If I might respond, it might help to have some clarification as to whether we've changed the law with respect to a power of attorney for a capable person in this regard, because I think there should be consistency. I would agree with you; I think there should be consistency in both situations.

**Mr Sterling:** I don't think there is anything there for a capable person.

**Mr Stephen Owens (Scarborough Centre):** Just a quick question to Mr Winner. In terms of the sentence that talks about the termination of the guardianship, is it prudent to maybe put some thought into the nature of the termination, as to whether you would want that person to have the ability to complete the transaction involved, as it may be the transaction that has caused the other termination?

**Mr Winner:** Just to give you a premonition of the direction of our thinking on this amendment, we may be able to sever situations of death from situations of termination of guardianship. I think Mr Sterling makes some very persuasive comments where you have a death occurring, and at that point in time either the administrator or the executor is clothed with authority. If, on the other hand, you have a termination of guardianship, you do need some continuity. If in fact no other guardian has been appointed as a substitute, then you need to be able to allow the existing guardian, whose guardianship has been terminated, to fulfil certain decisions that were undertaken prior to termination. Do you understand? I'm cognizant of your concern.

**Mr Owens:** I understand clearly what you're saying. I guess my concern again is, if the transaction or issue at hand is the cause of the termination, then how does one protect the person whose wishes have been countermanded or a transaction that's not prudent or in the best interests of the individual?

**Mr Winner:** That's a legitimate point and we'll look at that too in redrafting the section.

**Mr Owens:** Thanks.

**The Chair:** Do we have unanimous consent to stand this one down? Agreed? Thank you.

It seems the committee has a small procedural problem. I'll let the clerk explain it to everybody.

**Clerk of the Committee (Ms Lisa Freedman):** I just want to interrupt now so that if there's a need to go to the House leaders, I can get some direction from the committee.

The order of the House from the House leaders requires all amendments to be filed with the clerk by 4 pm on September 15. We do not start Bill 110 until September 16, which means technically, according to the order of the House, I would have to have all Bill 110 amendments by September 15 at 4 o'clock and there would be no opportunity in committee to change any of those amendments whatsoever.

The House leaders do have the authority to change this order of the House. One suggestion may be that in keeping with the spirit of the order of the House, we ask the House leaders to change it to read that all amendments on Bills 74, 108 and 109 be filed with the clerk by September 15 at 4, and Bill 110 amendments be allowed up till 4 o'clock on September 16. I'm looking for direction from the committee.

**Mr Sterling:** Why do we need any limitation at all on when amendments can be put forward?

**The Chair:** Order of the House.

**Mr Sterling:** No. I know that, but what if we sit past 4 o'clock—if everybody sitting around here says, "We've got three more sections to deal with. Let's deal with them," or whatever it is, and then get retroactive, and somebody comes up with a change of a word? I don't know what their intention was with regard to that. Maybe it was to give us notice of the government's intention in terms of amendments.

**Clerk of the Committee:** As it stands now, we're stuck with the order of the House. That's why I said I'm looking for direction from the committee. If the committee

just wants me to point out the problem to the House leaders and see what the House leaders can work out so that some flexibility is allowed on the 16th, whatever the committee wants, I can pass that on to the House leaders.

**Mr Sterling:** I would like the ability of anyone to introduce an amendment until we complete matters in committee on these four bills.

**Clerk of the Committee:** So you're looking for the ability to introduce amendments right up until 4 o'clock on the 16th, when we place all amendments.

**Mr Sterling:** Yes.

**Mrs Sullivan:** It seems to me that if the House leaders have the authority under the order from the House to alter the time, it should be altered for all of the bills and not simply for 110.

**Mr Winninger:** I think we should leave that to negotiations between the House leaders. There may be reasons why the first three bills should have amendments filed on a different date than Bill 110. There may be technical reasons.

**Mr Jim Wilson (Simcoe West):** There are no technical reasons. This was a political decision made by Dave Cooke to impose these restrictions on us. We need as much flexibility as possible right up till the last minute, and that's the direction the House leaders should be given.

**Mr Winninger:** I'm sorry, Mr Chair, but—

**Mr Owens:** We were having a good day up to this point.

**Mr Jim Wilson:** I don't care if you were having a good day. You closed down these hearings last night at 6 o'clock.

**Mr Winninger:** —Mr Wilson interrupted me. I did have the floor.

Interjections.

**The Chair:** Mr Winninger still has the floor.

**Mr Winninger:** I'm sorry, but Mr Wilson has a short memory. He and his colleague walked out when we were prepared to sit last Tuesday night—just walked out of the committee proceedings—so I think it's rather—

**The Chair:** Order, please, on the discussion.

**Mr Jim Wilson:** On a point of privilege, Mr Chair: I'm not letting Mr Winninger get away with that comment. We stayed here till 10 o'clock at night. The committee was clearly bogged down, and you people recessed 20 minutes later. I think the record is clear.

**The Chair:** Thank you, Mr Wilson. That is not a point of privilege. Mr Winninger, continue.

**Mr Winninger:** I think this is a matter that should be left to negotiations between the House leaders. I don't know that we should be extending specific dates for the filing of amendments on Bills 74, 108 and 109 at this stage. I prefer the latter option, that the clerk will approach the House leaders, make them aware of the problem, and deal with it accordingly.

**The Chair:** Thank you, Mr Winninger. Hansard on this discussion will be passed on to the House leaders, and they will determine the appropriate action.

**Mrs Sullivan:** We recognize that all of these bills are interrelated. If amendments are put to 110, in fact there may be a requirement for amendments to some of the other bills. It's illogical not to keep all of the bills open so that amendments can be put until the very end.

Had 110, under the schedule, been before the committee prior to the time that all amendments were to be filed, all amendments relating to all of the bills would have been filed at the same time and all of those bills would be open before the committee. What's occurring now is that when indeed there might have to be companion amendments to other bills, those amendments would be simply left out, and indeed the legislation, such as Bill 108, may in certain sections be unworkable.

I think the House leaders will have to understand the intense interrelationship between all of these bills and that Bill 110 is an important part of that interrelationship and that there is a back and forth between Bill 110 and all of Bills 108, 109, 74 and other pieces of legislation.

**The Chair:** Thank you, Ms Sullivan. Maybe it would be very worthwhile for each of the caucuses to talk to their House leaders on this, but you're quite correct in what you've just said. Agreed? Okay.

Back to the clause-by-clause: We need unanimous consent on the government reprint on section 37. Agreed? Carried.

We need unanimous consent on the government reprint on section 38. Agreed.

On PC motion, paragraph 39(4)1.

1140

**Mr Sterling:** If members would look not in the original ones, but there's one that has been amended since that time and is scratched in pen by legislative counsel.

**The Chair:** Mr Sterling moves that paragraph 1 of subsection 39(4) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by striking out "more than" in the second line.

Comments?

**Mr Sterling:** Under the present section, the idea here is to give the guardian of the property some opportunity, under subsection 39(3), to make gifts or loans and charitable gifts to a person's friends and relatives, and then it instructs the guardian as to what he or she must have in order to be able to do that; in other words, to make certain that there's enough money left to take care of the person whom the guardian is responsible for.

The present section puts a test in front of the guardian. It says that in order to either give a gift or a loan to the person's friends or relatives or make a charitable donation, the guardian may only do that if the property is and will remain more than sufficient to satisfy the requirements of subsection 39(1). So it puts a very high test on the guardian to have not only adequate funds to take care of the person for the rest of his or her life but to have "more than," and nobody knows what "more than" is.

I just thought that taking out the words "more than" would give the guardian a real flexibility to do these two things in subsection 39(3) if he thought it was probably



what the person he's taking care of would want to have done.

If, for instance, during his lifetime the person had given to his or her church a sum of \$1,000 or \$2,000 in his annual gift offerings to the church and it was the guardian's opinion that there was a sufficient income to take care of that person for the rest of his or her life, he would continue to do that kind of thing. But when you put in the words "more than," in my view it puts too high a test and the guardian might feel reluctant to do that kind of thing.

**Mr Winner:** We agree with that amendment.

**The Chair:** Further comments?

Motion agreed to.

**The Chair:** On the government reprint paragraphs 39(4)2 to 6? Agreed? Carried.

Government reprint subsection 39(5)? Agreed? Carried.

**Mr Sterling:** I had a motion I was going to move on section 39.1, but it depends to some degree what happens to subsection 34(2), which has been stood down, so I would ask that our consideration of section 39.1 be stood down as well.

**The Chair:** Agreed? Agreed.

Government reprint subsection 41(1). Agreed? Carried.

Government reprint subsection 41(3). Agreed? Carried.

Government reprint subsection 41(4). Agreed? Carried.

Government reprint subsection 42(1.1). Agreed? Carried.

PC motion on subsection 47(2.3)?

**Mrs Sullivan:** Could I ask a question about subsection 42(2)? It's really to understand what current practice is.

The guardian under this section is required to give a copy of the financial statement to the person, the guardian of the person or the attorney for personal care. There's no obligation for family people to obtain that financial statement. I'm thinking if, by example, the spouse is not the guardian or if the parent is not the guardian, how can judgements be made by other people who are close to the person and who have an interest in the person's welfare as to whether the guardian is in fact dealing with the financial matters of the person in an appropriate way?

I'm asking the question because I don't know what the current practice is, but a judgement with respect to the suitability of the decisions being made by the guardian to perhaps put an application forward to replace the guardian would be very difficult when another person will not have access to the information on which that application could be put forward.

1150

**Mr Winner:** I hate to make you put the question twice, but I think that's a question counsel is probably better equipped to answer and I would ask when he returns that we revisit that issue.

**Mrs Sullivan:** Okay. We'll do that—subsection 42(2).

**The Chair:** PC motion, subsection 47(2.3).

**Mr Sterling:** Is there a government motion that really comes in front of mine?

**The Chair:** That's a reprint.

**Mr Sterling:** I've got 47.1(1)—okay, that comes next. I'm sorry.

**The Chair:** Mr Sterling moves that subsection 47(2.3) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by removing the word "shall" and replacing it with the following: "are authorized to act."

**Mr Sterling:** This is on page 23 of the reprinted bill, if you're trying to find it.

This seems to place an absolute obligation upon the remaining attorneys in a multiple power of attorney to act, or an alternative attorney. Often a person will put in there, when they put a multiple power of attorney, "I ask my spouse or I authorize my spouse to act on my behalf, but if she is unable or unwilling to act, then I appoint my sons, Peter and John, to act." It may be that Peter and John are unable or unwilling to act. This seems to say they have to act, and therefore I'm just saying they are authorized to act rather than they shall act. It's really wording as much as anything, but I think it's more accurate as to what happens.

**Mr Winner:** We agree with the amendment in principle and you've got the replacement wording correct, "are authorized to act," but there's an additional word after "shall," the word "continue." That has to come out as well.

**Mr Wessinger:** May I just make a suggestion here? Why couldn't you just replace "shall" with "may," and then you wouldn't have to—

**Mr Winner:** There was some discussion about this earlier. Perhaps counsel who drafted the original section can assist with this.

**Mr Sterling:** I would like to withdraw my motion, Mr Chairman.

**The Chair:** You have withdrawn the original and you move this one now.

**Mr Sterling:** Yes.

**The Chair:** Mr Sterling moves that subsection 47(2.3) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by removing the words "shall continue" and replacing them with the following: "are authorized to act."

**Mr Winner:** That would be acceptable.

Motion agreed to.

**The Chair:** On the government reprint, subsections 47(2.1) to 47(2.3), as amended. Agreed? Carried.

On the government reprint, subsections 47(6) and 47(7).

**Mr Winner:** It's a deletion.

**The Chair:** Agreed? Carried.

On the government reprint, subsections 47(9) and 47(9.1) Agreed? Carried.

On the government motion on subsection 47.1(1).

**Mr Winner:** There's a Liberal motion.

**Mrs Sullivan:** On a point of order, Mr Chairman: I want to be sure we were dealing with these amendments separately, because I think it's clear that the government is also concerned about the test of capacity for giving

personal care, as we have been, and I shall read my amendment into the motion.

**The Chair:** Mrs Sullivan moves that subsection 47.1(1) of the bill, as reprinted to show the amendments proposed by the Attorney General, be struck out and the following substituted:

“Capacity to give power of attorney for personal care

“(1) A person is capable of giving a power of attorney for personal care if he or she understands:

“(a) that the attorney will be able to do, on the person’s behalf, anything in respect of the person’s personal care that the person could do, if capable, subject to such conditions and restrictions as may be set out in the power of attorney;

“(b) that the attorney is required to make decisions in accordance with the wishes expressed or instructions given by the person while capable, or in the absence of such wishes or instructions, in accordance with the best interests of the person;

“(c) that the attorney will encourage the person to participate, to the best of the person’s abilities, in making decisions with respect to his or her personal care;

“(d) that the attorney must account for decisions made with respect to the person’s personal care;

“(e) that he or she, if capable, may revoke the power of attorney for personal care;

“(f) whether the proposed attorney has a genuine concern for the person’s welfare; and

“(g) the nature and effect, including the likely consequences, of a decision to execute or revoke a power of attorney for personal care.”

**Mrs Sullivan:** In putting together this amendment we’ve tried to look at various scenarios in relation to the capacity for understanding what an attorney will be able to do, for understanding the obligations of the attorney that the person is making.

I’ve thought about the nature of this kind of test on a person who is partially incapable, I suppose. I’m thinking of a developmentally disabled person. I think everything that is included in this section or that I have included in my amendment would be a reasonable test for someone who is, by example, developmentally disabled. The obligation or the assumption as well is that if the person has the capacity to consent, these issues will be put before the person as well in determining that capacity.

1200

I note that the government’s amendment is less demanding. It seems to me that a person who is providing a power should also understand that he will be participating in decisions, when possible, along with the attorney and that the attorney does have a requirement to be accountable for the decisions. I think that those tests of capacity, of the understanding of not only the obligations of the attorney but the obligations and the rights of the person himself, are part of a really important test of capacity.

I think as well that it almost parallels the tests of capacity for selecting a power for property care, and I think this is a good amendment.

**Mr Winninger:** As you know, we have different criteria for the selection of an attorney for property versus personal care, just starting with age. But I think the important point to remember here is that we’re trying to keep the test of capacity to appoint an attorney as simple and as comprehensible as possible—namely, the appreciation that the proposed attorney has a genuine concern and that the person may need to have the proposed attorney make decisions for the person.

What you’ve set out here with all these criteria in the Liberal amendment seems to be a very tall order: to demand capacity to understand all these responsibilities and duties for the attorney, which are, I might add, already set out under the “duties and obligations” section later on in the bill. These are the duties and obligations of attorneys for personal care, for which they’re held accountable. To ask that the vulnerable person understand all these complex duties and obligations I think is well beyond the need that we need to ascertain capacity to appoint an attorney for personal care. I think you’ve gone in the opposite direction from the direction the government is going in: to empower individuals to appoint their own attorney and thereby have a decision-maker preference.

**Mr Sterling:** I reluctantly must agree with the government on this point—not reluctantly; it’s getting near lunchtime, I guess. At any rate, the concern I have is that, overall, the thrust I have tried to maintain in terms of doing all this is to make it as simple as possible. I understand what Ms Sullivan is doing here in terms of trying to ensure the wishes of the incapable person and that he or she is fully consulted and that kind of thing, but it also leads to another problem if the qualifications as to the understanding of the grantor of the power of attorney for personal care are increased substantially. Then you always open the problem of attack. If you give a lawyer or an advocate or somebody who is making mischief seven sections to attack, then he might be able to say to the attorney, “Can you remember whether or not you advised the person on all the ways that he could terminate a power of attorney for personal care?” etc. I don’t think those attacks are going to come very often but they will come, and I think we’re better off with the two sections that have been proposed on the government motion. I hope you understand my concern.

**Mrs Sullivan:** I think it’s probably valuable for me to withdraw this motion. The intent of it was really to ensure that, in determining that a person was capable, we were also ensuring that the person was informed. This was my approach to that obligation, and I don’t know that it’s anywhere else in the bill.

**Mr Winninger:** I might add that when there is an application to validate a power of attorney, that does trigger the advocate also to explain the implications of that substitute decision-making.

**The Chair:** So you withdraw, Mrs Sullivan?

**Mrs Sullivan:** Yes, I do. I also have a second amendment, subsection 47.1(1.1).

**Mr Sterling:** On a point of order, Mr Chairman: Should we not deal with the government motion. It’s on the floor, is it not?



**The Chair:** Yes, and being as we're past 12 o'clock, I was thinking of recessing for lunch.

**Mr Sterling:** Why would we not carry that motion now?

**Mr Winninger:** I'd be pleased to.

**Mrs Sullivan:** Just a minute. My motion is on that exact section, isn't it?

**The Chair:** No, it's on the section just after.

**Mrs Sullivan:** Sorry. I apologize.

**The Chair:** So, the government on subsection 47.1(1).

**Interjection:** Carried.

**The Chair:** Could we have it moved first, please?

Mr Winninger moves that subsection 47.1(1) of the bill, as reprinted to show the amendments proposed by the Attorney General, be struck out and the following substituted:

"Capacity to give power of attorney for personal care

"(1) A person is capable of giving a power of attorney for personal care if the person,

"(a) has the ability to understand whether the proposed attorney has a genuine concern for the person's welfare; and

"(b) appreciates that the person may need to have the proposed attorney make decisions for the person."

Motion agreed to.

**The Chair:** Mrs Sullivan moves that section 47.1 of the bill, as reprinted to show the amendments proposed by

the Attorney General, be amended by adding the following subsection:

"Validity

"(1.1) A power of attorney for personal care is valid if, at the time it was executed, the grantor was capable of giving it even if the grantor is incapable of personal care."

**Mrs Sullivan:** I think this is an important amendment. I'm told by counsel that it is perhaps not necessary in that it would be implied. I believe, in fact, that it is needed in the bill. There already is confusion in the bill. If you look at clause 50(6)(b), where I will also have an amendment to put forward, it's very clear there's already confusion in this area. I believe it's an important amendment to include to ensure there is no confusion at all.

**Mr Sterling:** I think it's a good addition to the bill as well. If anything, even if some might argue that it's not necessary, we're going to try to have these kinds of attorneys made in absence of lawyers who might argue that, and I think it's good for clarification of the general public to know that this is not a necessary requirement in order for an incapable person to sign such a power of attorney.

**Mr Winninger:** We feel it's a useful amendment and it gives equivalency to subsection 9(1), which is the exact reciprocal section under "property" that this is under "personal care."

Motion agreed to.

**The Chair:** This committee will now stand recessed until 2 pm this afternoon—promptly, please.

The committee recessed at 1211.

## AFTERNOON SITTING

The committee resumed at 1414.

**The Chair:** We'll now go to the government reprint on subsection 48(1). Comments?

**Mr Winninger:** I note that subsection 48(1) makes reference to subsection 48(3). Since there's a Liberal motion and a PC motion affecting subsection 48(3), we need to deal with that first.

**The Chair:** Okay. We'll stand down subsection 48(1) and go to the PC motion on subsection 48(2).

**Mr Winninger:** It's on subsection 48(3) and subsection 48(4).

**The Chair:** No, subsection 48(2) first. Mr Sterling.

**Mr Sterling:** Which one are we doing now?

**The Chair:** We're going to stand down subsection 48(1) until we do subsections 48(2) and (3).

**Mr Sterling:** Do I have an amendment on subsection 48(2)?

**The Chair:** Yes, you do.

**Mr Sterling:** Is it a new one that I've got?

**Mrs Sullivan:** Neither of us have it.

**Mr Sterling:** Oh, I see one, yes. I haven't submitted it. It had more to do with my amendment to subsection 10(2), if that had passed, so it really has no bearing at this time.

On subsection 48(2), now that we have changed subsection 10(2), I hope members of the committee are cognizant that the same requirements for witnesses for power of attorney for personal care are in place as for property. I'm satisfied myself, so I'm not going to put forward an amendment on subsection 48(2).

**The Chair:** Okay, we move to the Liberal motion on subsection 48(3).

Mrs Sullivan moves that subsection 48(3) of the bill, as reprinted to show the amendments proposed by the Attorney General, be struck out.

**Mrs Sullivan:** The rationale in this instance is exactly as it was in the earlier case. A witness ought not to be making an assessment of the capacity of the person who is involved in providing a power of attorney.

**Mr Winninger:** We accept that amendment.

Motion agreed to.

**The Chair:** We now have a government amendment.

**Mr Winninger:** Could we just have a moment here to consult about these various amendments?

**Mr Sterling:** In the notices of amendments, I had put subsections 48(3) and (4), but since Ms Sullivan's motion to delete subsection 48(3) has already carried, I have a motion to amend subsection 48(4). Do you want me to put that motion now, Mr Chairman?

**The Chair:** Please.

**Mr Sterling:** I move that subsection 48(4) of the bill, as reprinted to show the amendments proposed by the

Attorney General, be deleted, with the following being inserted:

"48(4) Each witness shall, if the witness has no reason to believe that the grantor is incapable of giving a continuing power of attorney or making decisions in respect of which instructions are contained in the power of attorney, sign the power of attorney as witness."

**Mr Winninger:** In principle, that amendment is acceptable, but there's still a problem with the reference to "continuing power of attorney" in the amendment that Mr Sterling just read out. I'm not so sure he meant to read it in precisely that form. There should be reference made to "power of attorney for personal care" instead of "continuing power of attorney." The handwritten amendment has the proper wording.

**Mrs Sullivan:** Mr Chairman, the government's bill uses the words "continuing power of attorney."

**Mr Fram:** It's a mistake.

**Mrs Sullivan:** Do you have an amendment?

**Mr Winninger:** I discussed the matter with Mr Sterling informally and I think he knows where we're going.

**Mr Sterling:** I would like to withdraw the motion I have just read, Mr Chairman.

**The Chair:** Mr Sterling moves that subsection 48(4) of the bill, as reprinted to show the amendments proposed by the Attorney General, be deleted and the following substituted:

"48(4) Each witness shall, if the witness has no reason to believe that the grantor is incapable of giving the power of attorney for personal care or making decisions in respect of which instructions are contained in the power of attorney, sign the power of attorney as witness."

**Mr Winninger:** That's certainly acceptable, Mr Chair.

**The Chair:** Okay. It's my understanding all you did was eliminate "continuing" from the previous motion.

**Mr Sterling:** From the previous motion I proposed, yes.

**The Chair:** Thank you. Agreed?

Motion agreed to.

1420

**The Chair:** Is it my understanding that the government will not be putting forward its motion on subsection 48(4)?

**Mr Winninger:** Yes, we'll withdraw that motion, Mr Chair.

**The Chair:** It's not necessary, but thank you.

On the government reprint on subsections 48(3), (4) and (5), as amended, discussion? Mr Winninger.

**Mr Winninger:** I was just going to suggest it carry as amended, if we're voting on all three subsections together.

**The Chair:** As amended.

**Mr Winninger:** Yes.

**The Chair:** Government reprint subsections 48(3), (4) and (5), as amended, agreed?



**Mr Wessenger:** Don't we have to go back to subsection 48(1), though?

**The Chair:** Yes.

**Mr Winninger:** Right now we're voting on subsections 48(3), (4) and (5) as amended.

**The Chair:** Right. That's agreed? Carried.

Now we go back to the government reprint on subsection 48(1).

**Mr Winninger:** I would move an amendment to subsection 48(1) which would delete reference to the present subsection (3).

**The Chair:** It has to be written out.

**Mr Winninger:** After the renumbering, though, it will be—

**The Chair:** Maybe we could stand it down till it's written out.

**Mr Winninger:** Yes.

**Mr Sterling:** Isn't that done automatically regardless?

**Mr Winninger:** The renumbering, you mean?

**Mr Sterling:** No, the reference to other sections.

**The Chair:** No.

**Mr Winninger:** I would move then that we stand it down until we have a proper form for the motion.

**The Chair:** Can I have unanimous consent to stand that down? Agreed? Thank you.

Now we go to a Liberal motion on clause 49(2)(c).

Mrs Sullivan moves that clause 49(2)(c) of the bill, as reprinted to show the amendments proposed by the Attorney General, be struck out.

**Mrs Sullivan:** The reason for this motion is that it reflects some of the concerns that were placed before the committee with respect to the obligations to file a guardianship plan with the public guardian and trustee if one has been given a power of attorney for personal care by an individual. The sense is that the copy of the power of attorney, which expresses the capable wishes of an individual who is providing that power, should be adequate for the purposes of the PGT.

**Mr Winninger:** It's our position that everyone should have a guardianship plan for a validated power of attorney, and I can't understand why you would wish to remove that safeguard.

**Mr Sterling:** The validated power of attorney that would happen here would be important only if the person was in certain settings. Is that not correct?

**Mr Winninger:** I'm going to let counsel speak to this because it is an important element of how this machinery will operate.

**Mr Fram:** The validated power of attorney is like a guardianship order. It allows the guardian to enforce his or her decisions on somebody who doesn't want those decisions. As the bill was changed by the government amendments, most people will have powers of attorney, selecting a family member to make medical decisions and no problem will happen. They won't be validated. They will just go along with the wishes of their relative. But in some

cases where you have a situation of a person with Alzheimer disease who develops wandering patterns of behaviour where some decisions are going to be made that are coercive in effect, that's when you'll need the validated power, because the objection of the person can't be allowed to override what's in his best interest. That's when you need the guardianship plan.

**Mrs Sullivan:** Let's look at the process. The power of attorney has already been registered in an expedited—

**Mr Fram:** That's section 50.

**Mr Winninger:** We're not quite there yet.

**Mrs Sullivan:** I still think the power of attorney will contain the specific instructions which must be followed by the attorney, and with the filing of the copy of the power of attorney, that in fact is the plan.

**Mr Winninger:** The copy of the power of attorney may say as little as, "I appoint so-and-so my power of attorney." There's always some boilerplating in these forms, but unless the grantor of the power of attorney sets out specific instructions to the attorney in the event of incapacity, those would be absent. So it's appropriate, I would submit, that there be a plan of guardianship set out since decisions made by the attorney under a validated power may well override the objections of the vulnerable person.

**Mr Sterling:** I don't mind a guardianship plan being there. It's probably essential in terms of the kind of power that an individual is turning over to somebody else under these contemplated circumstances. I'm still interested in hearing debate on it, however. Under subsection (4), the advocate is called in to make certain the grantor understands what's going on. I don't mind that intervention at that stage because we're talking about, as I say, a Ulysses kind of situation. The advocate doesn't review the plan?

**Mr Fram:** It would be the public guardian and trustee who would review the plan.

1430

**Mr Sterling:** Is that somewhere in here or is it just assumed that would happen? Is it necessary that the public guardian and trustee has to meet with every one of these? Is that the intent?

**Mr Fram:** It's basically believed that they'll be sent in. The plan will be sent in, the assessments will be sent in, so he now has a number of pieces of paper. He may check out where the person is, call the physician or whatever, but if he's satisfied that the people have thought about what kinds of decisions are going to be made in this other person's life, he will be satisfied with the plan and he will validate the power of attorney.

If he doesn't, the implication of subsection (10) is that he will refuse to validate the power of attorney and shall apply to the court to settle the matter. One can expect that in many cases plans of guardianship will be relatively simple, but in situations, for example, where there's complex medication or the person is not living in an institution, more will have to be in there. If somebody's living in X nursing home and being moved from floor to floor and

being confined to stop him wandering and getting the ordinary food that's given in the nursing home, it will be a relatively straightforward document of about a page long.

It will always be a document where the public guardian and trustee will have to have an idea of what kinds of decisions have to be made in this person's life, sort of the ambit of the situation that person is in. It will be a standard form document that will be provided by the public guardian and trustee to the family so they can fill it out as part of the application. If he's not satisfied with it—it isn't filled out—he will not validate it until he gets a document that describes the kinds of decisions that are going to be made in this person's life, where he is going to be living, what his situation is likely to be.

**Mr Sterling:** Okay. That's fine.

**Mrs Sullivan:** I guess part of my difficulty with this is that the power and the duties granted to the attorneys are quite clear in the legislation. They have to act in a certain way. They have to enable and ensure that the person participates in decisions along the way. How can a plan of guardianship that fully indicates evolving participation of the person be filed?

The power of attorney that's given by the person includes no static plans that the attorney will be involved on a continuing basis in certain specified areas of decision-making, whether it's in relationship to housing decisions, shelter or medical care and treatment, depending on what the individual has decided that attorney should be responsible for, and one of the obligations of the attorney is to ensure that to the best of the ability of the person, that person is involved in those ongoing decisions that are being made. It seems to me that the authority to the attorney comes from the power of attorney rather than from the guardianship plan which is being placed only by the attorney.

**Mr Winninger:** To come back to my earlier point, there may be grantors of powers of attorney that may set out in their instrument very detailed directions as to accommodation, hygiene, education clothing and what have you. I would suggest that the guardianship plan that's filed with the PGT would have to reflect what's in the instrument that the grantor signed.

On the other hand, there may be very general powers of attorney for personal care that just say, "I want so and so to make decisions regarding my personal care." In this particular case, if the guardian has that wide latitude to make decisions, we're asking that the attorney for personal care file a fairly detailed plan so that the PGT will know what lies in the future for this incapable person.

**Mr Sterling:** On the certificate that's issued by the public guardian and trustee, if, for instance, the PGT decided that the guardian was to have decisions relating to the health care or a particular aspect of the health care of the grantor, would that be stated specifically in the certificate that is given by the PGT? The power emanates, according to section 49, out of the certificate.

You see, my concern is the person who's going to provide that service for this vulnerable person. The guardian comes in and says, "This is to be done for my child," or

whatever. That health care provider is going to learn to look for a certificate, or some other kind of worker who might be meeting the needs of this particular individual. I would view that the guardianship plan is necessary in order for the PGT to be able to figure out what the scope of that certificate might be. Am I right or wrong?

**Mr Fram:** Yes, the certificate will set out the scope of the authority. It will derive mostly from the assessment or the assessments. The assessors will agree on the functions that the person is incapable of. It will be powers in relationship to the areas of life that the person can't make decisions about. I think most of the certificate will say that the person certified as guardian may make decisions about these areas of the person's life, and that will relate back to the assessments.

**Mrs Sullivan:** I think that's where there's part of the problem. The power of attorney may in fact be granting quite limited authority to the attorney. None the less, what's required here is a full guardianship plan.

1440

**Mr Sterling:** I think the power of attorney almost becomes secondary in this circumstance. It's the certificate issued by the PGT that is the key document because it is the real authority the service provider looks to in terms of protecting the interests of the vulnerable person. So two documents will be presented, I assume: the power of attorney, plus the certificate. The power of attorney will show that this person has signed a document which basically says that this person who's now refusing treatment or refusing to be bathed or whatever it is, has said in the past he agrees with this and the PGT has said, "Yes, the assessment was done." The certificate says this power is given to the guardian to basically enforce this to make certain the person is clean or bathed or whatever it is.

So there are two documents associated with that, but it seems to me that the power is quite all-consuming and a very significant power that one person is giving to another person in society. Therefore, I don't think that asking for a guardianship plan is an excessive requirement. That guardianship plan may be two lines or it may be 20 pages, depending on how extensive that guardianship is to be.

**Mrs Sullivan:** Let me suggest an example where the power of attorney is given by a person who says that he wishes the attorney, in granting consent to treatment, not to consent to extraordinary measures to prolong life and that is the full extent of the instruction in the power. This section would still require a guardianship plan. This section does not limit the guardianship plan to the specific duties the individual is granting the attorney the power to do. It's a guardianship plan. It's not a guardianship plan with respect to the instructions contained in the power.

**Mr Fram:** I think Ms Sullivan has in mind a very narrow power of attorney. Under subsection 47(3), a power can be as narrow as the person wants to make it: "I appoint a person to make only these kinds of health care decisions for me and in these circumstances to decide only this way."

In that case, there would not be much point in validating a power of attorney of that kind because you would



really have to go for guardianship if you are going beyond the scope of the power of attorney. Most powers of attorney will say, "I want my daughter Mildred to be my attorney for personal care," and then will list the instructions with respect to anything they care about. But that document will be a very broad document. If the person who makes it gets into an accident, becomes incapable, all of the personal care decisions in that person's life—where they live, the kind of food that's presented—will be made by their attorney. There will be no need for guardianship and, where there's objection by the grantor, no need for validation.

So we're talking about, when we come to validation, a broad power of attorney that may have some instructions in it and will serve as a guardianship order, because it's only being sought when some decisions have to be forced on the person. That's when we'll need this guardianship plan.

**Mr Winninger:** Just in addition, and to come back to Ms Sullivan's earlier point about a power of attorney that specifies that lifesaving measures should be withheld, you made an earlier point about a power of attorney that may only speak to the withholding of life-support measures in certain instances. If we take that one as our example, up until the point where a decision would have to be made to withhold lifesaving measures, you'd still need to make decisions regarding that person's personal care in other ways. So I don't know whether even in that instance you allude to, you could set aside the need for a guardianship plan.

**The Chair:** Further discussion? No further discussion? Okay, we will now proceed to the vote on the Liberal motion on clause 49(2)(c). All those in favour? Opposed?

Motion negatived.

**The Chair:** Another Liberal motion, subsections 49(6) and (7).

Mrs Sullivan moves that subsections 49(6) and (7) of the bill, as reprinted to show the amendments proposed by the Attorney General, be struck out and the following substituted:

"Validation by PGT

"(6) The public guardian and trustee may validate the power of attorney if he or she receives notification from the advocate,

"(a) that the grantor does not oppose the validation of the power of attorney; or

"(b) that the grantor refuses to meet with the advocate.

"Certificate

"(7) As soon as he or she receives the notification described in subsection (6), the public guardian and trustee may validate the power of attorney by issuing a certificate to the attorney."

**Mrs Sullivan:** I think this is a self-evident motion. It provides the right to refuse an additional meeting with another person with respect to the process here and preserves the right of the person not to meet with the advocate. The way it reads now, if the person refused to meet with the advocate, because of the latter wording, the PGT could not validate the power of attorney.

**Mr Winninger:** Just briefly, by refusing to meet with an advocate, that person would then, under your amendment, give up all his or her legal rights to challenge the validation. For that reason, we can't accept it.

**Mrs Sullivan:** Well, he is not giving up his rights; he's giving up the explanation.

**Mr Winninger:** But what you're saying is that if the person refuses to meet with the advocate, what you have is automatic validation.

**Mrs Sullivan:** No.

**Mr Winninger:** And you're taking away the legal and civil rights that the person would normally enjoy otherwise.

**Mrs Sullivan:** No. The person can still oppose the validation. The advocate's involvement under subsection 49(4) is to tell the person that the validation is proposed, talk to him or her about the powers that the person has already given, because the person has written the power of attorney, and tell him that he can oppose it.

A person can say, "No, I don't need to meet with the advocate." If the person says, "No, I don't want to meet with the advocate," then the process can still continue and the person can still oppose. The duties of the advocate here are to provide information.

**Mr Winninger:** I don't agree with you but I'm going to let Mr Fram respond.

1450

**Mr Fram:** I think the consequences of your amendment are that the public guardian and trustee will be validating the power. So he will be giving the attorney coercive power over the life of the person who has refused to meet with the advocate. That's a pretty stiff penalty for not meeting with the advocate, on the one hand.

We already know that the person whom the advocate sets out to visit has significantly diminished capacity and has already been assessed by two people as being incapable of making certain kinds of decisions. So to penalize that person by saying: "Well, your behaviour was a problem in the first place. If you refuse what is our best opportunity to reach out to you and say, 'Look, do you oppose or do you not oppose,'" the conclusion is that his civil rights are down the tube and he doesn't get a chance in court or anything else. That is a pretty severe consequence of not wanting the advocate to visit.

**Mr Sterling:** I think the problem here is that what everybody would probably like is something that's sort of halfway between. There's a problem in that the public guardian and trustee may find itself in a position, for some reason, of not being able to get a notice from an advocate. Should that, as well, negate the whole process of having a valid power of attorney?

I guess what I would prefer is some kind of fudge words or whatever, where the PGT would have some kind of discretion, after due diligence, to have an advocate interview or whatever. If he were satisfied through some other kinds of means that the person was not opposing this, be it somebody else, if the PGT himself had sent somebody in and interviewed him or whatever—what I'm trying to

find is that the sanction seems to be yes or no, because of an advocate. I guess the sanction should be yes or no, as long as the PGT is satisfied that the person has been consulted and that he or she doesn't oppose this.

**Mr Wessinger:** I have a concern about this section, and there may be an answer to this. It seems to me that you could end up with a roadblock here: The application is made, the person for whom the certification is sought refuses to see an advocate, and the result is that there's no other way to validate the power of attorney. Am I right?

**Mrs Sullivan:** That's right.

**Mr Fram:** That's right. You'd have to go to court.

**Mr Winninger:** You go to court for guardianship in that situation.

**Mr Wessinger:** You'd have to go to a full guardianship.

**Mr Winninger:** And the PGT, of course, can go to court for guardianship in that eventuality.

**Mr Wessinger:** Right. So it'll still be open to the person to apply for guardianship, based on the power of attorney, to the court.

**Mr Winninger:** Oh, certainly. And in that case it would be up to the vulnerable person to oppose or not, either with or without counsel.

**Mr Wessinger:** This is really a short method of getting in the position of "equivalent to a guardian." That's why I just wanted it to be clarified.

**The Chair:** Mr Winninger.

**Mr Winninger:** I think I addressed the point I wanted to address.

**Mr Sterling:** What you are trying to do here, though, is satisfy the PGT that the grantor doesn't oppose it, and the PGT wants to be satisfied that the grantor has been advised. Why wouldn't you then give the PGT the opportunity to meet those in whatever way the PGT so chose?

**Mr Winninger:** If you're looking at some kind of written waiver on the part of the person, one might well question the capacity of a person to sign a written waiver of his or her right to see an advocate. You could be into a real thicket there.

**Mr Sterling:** Let's compare this to something that happens every day in this province in terms of separation agreements between estranged spouses. We require that the same lawyer can't advise one party as well as the other party so that we're certain the advice is not tainted. That's done so that a judge who is sitting there after says, "Look, you two people sat down and you were advised by this. You've got to live by this agreement that you entered into," and there was no undue influence or whatever it is.

I equate this one, if you want to have the same thing, that the grantor and the attorney are there and you're saying, "Okay, we want to be absolutely sure that the grantor is properly advised," so that if a dispute arises, the judge will know what's happened. What I'm saying is, the public trustee is the judge in terms of deciding the validity of this guardianship, so why are you saying the advocate alone must be there to advise the grantor and not allowing the

judge to short-circuit it, if that's the last resort that has to be done?

**Mr Winninger:** The advocate makes the expedited process work, but if it doesn't work, then you go the longer route. Mr Fram has something to add.

**Mr Fram:** It is essential to recognize that nothing works in Bill 108 without advocates. All of the court process, all of the validation processes depend on there being an advocate to come and advise the person whose rights might be lost, so you can't go ahead with a court application unless an advocate visits. That's sort of the central theme of this whole bill, and that's deliberate. We want to be sure that people know what's going on in their lives.

**Mr Sterling:** The alternative is to force this person into court and go through the expense of court, the delay of court and all the rest of it. If the PGT says, "Okay, we're trying to expedite this whole thing to the two parties," and they can't get the vulnerable person to agree to come to see an advocate—he's had a bad experience with an advocate before or there's no advocate in the area or the Advocacy Commission has been shut down or whatever—if the PGT goes directly to the vulnerable person or whoever is giving it and says, "Look, do you understand what you're doing? This is what you are doing, I've got to give somebody else this right," why are we denying the PGT that as an alternative process?

1500

**Mr Fram:** The PGT is an administrator. He will act as guardian. He will act as guardian of property. He will act as guardian of the person. He is not a decider.

**Mr Sterling:** He is right here.

**Mrs Sullivan:** He's deciding.

**Mr Fram:** What does he decide in this section? He decides that he can accept that it meets the statutory criteria or it doesn't. If he says it doesn't and the person who sent in the application is dissatisfied with the PGT's decision, the PGT has to take it to court and let the court decide. So he's left in the role always as administrator.

**Mr Sterling:** I don't think you're right here, Steve. Because we're trying to get away from a court hearing, which I agree with, you're putting him in the position of making a decision, not only about the application, but he's going to have to write on that certificate how far that certificate goes. He's making a judgemental decision at that time. There's a right of appeal and all the rest of it that occurs later.

All I'm saying is, why on earth do you want to tie his hands if, through some quirk, the advocate cannot meet with the individual because the person is in Timbuctoo and there's a PGT representative there and the PGT representative can go right over to this thing and get it solved, be done with, and that's the end of it.

**Mr Fram:** The central principle is that the PGT role is to make decisions for people; the advocacy role is to allow people some choices as to options. It may be that validation isn't the right thing. Maybe the advocate will find that really what's at issue is whether this thing should be revoked at all, but those are the kinds of questions and the



kinds of issues the PGT is not going to be equipped to decide. That's why we have this advocate, who is essentially a voice of the person who's going to be losing his or her rights.

**The Vice-Chair (Mr Mark Morrow):** Any more comments or questions?

**Mrs Sullivan:** I think on this side we have problems with the situation where the PGT is obligated to refuse to accept the power of attorney as valid if the only reason for not doing that is that the person has refused to meet. The PGT is now obligated to refuse to validate the power, and the only alternative then is to proceed to court.

**Mr Sterling:** The problem with the section is that you're assuming that an advocate is going to be readily available across the province, and that may not be the case. I guess what I'm seeking is a little bit of flexibility on the part of allowing the PGT to say, "I am satisfied otherwise that the grantor knew what he was doing."

**The Vice-Chair:** Any further comments or questions? Seeing none, we'll vote.

**Mrs Sullivan:** We're having some discussion here that may mean there might be some movement.

**Mr Winninger:** I hoped I had laid Mr Wessinger's concerns to rest, but if I haven't, I see his hand up.

**Mr Wessinger:** I was going to give some explanation of your interpretation. If your interpretation is correct, then I have no problem with that section. I must say this is the interpretation that was given to me, and I don't know whether I agree with this interpretation, but I will accept counsel's opinion on it, and that is, let's just say the advocate cannot meet with the person. Then the public trustee gives his refusal. That's the next step.

Then the attorney can dispute the refusal, in which case, if the attorney disputes the refusal, I understand the interpretation is that the public trustee must apply to the court to validate. So it would be the public trustee's obligation to apply. The attorney could force the public trustee to apply to validate. That was the explanation given to me as the meaning of the section. If that's true, then I don't have any problem with it.

**Mr Winninger:** Subsection 49(10) is quite clear in saying, "If the public guardian and trustee refuses to validate the power of attorney"—under any circumstances—"and the attorney disputes the refusal, the public guardian and trustee shall apply to the court to decide the matter." As Mr Fram indicates to me, the attorney could seek an order of mandamus if the PGT declined to exercise his legislative function there.

**Mr Sterling:** That's fine and dandy, but you're talking about time and you're talking about expense.

**Mrs Sullivan:** Plus months of waiting.

**Mr Winninger:** And you're talking about overriding the desires of an incapable person.

**Mr Sterling:** Absolutely not. What I'm talking about is saying that if the PGT can't get an advocate in there for whatever reason, either refusal by the grantor or the fact that he can't find an advocate, the PGT could say, "I'm going to send in one of the people in our office, because

this is a very extreme case and we have to deal with this immediately," etc.

Why can the PGT not satisfy himself that in fact the grantor has been properly advised, knows what he is doing etc? All you're doing is asking the advocate to go and find that out for him as an agent of the PGT. That's really what this is all about.

**Mr Winninger:** I'll let Mr Fram speak to this.

**Mr Sterling:** He doesn't like the word "agent." I can read his eyes. I've been around him too long. Perhaps they can get a lawyer in town or somebody else in town who the PGT is satisfied can offer rights advice to this person as good as or better than an advocate. Why shouldn't you give the PGT that kind of discretion?

**Mr Fram:** I think a central or major function of the advocate is to do this. This is what people's lives are about. This is a statutory obligation. The fact is that there's no point in making the change here to this bill. That idea is central to the whole of the bill. Every time there's an application to court, every time there's an application to change an order, the advocate is the person who goes to find out what it is the person wants, to explain things. This is a group of people who will receive training and experience and who come from backgrounds that will best reach the person.

This whole process of paper guardianship in fact depends on our using advocates to reach down, instead of piles of paper and motions at court. We've sidetracked the courts or avoided the courts as much as we possibly can in this bill deliberately, only because we had some assurance in the whole of the bill that advocates would be there to explain what was going on and carry that voice, that communication, of what the person wanted to the process. Without them, this bill doesn't work at all.

1510

**Mr Winninger:** I don't speak for the public guardian and trustee, but I'm not so sure the PGT would want to be clothed with the kind of judicial power your proposal seems to clothe him or her with, making decisions as to whether advocacy can—

**Mr Sterling:** They have that power. What if they're not confident of the ability of the advocate who has advised this person? I hope the PGT would go back to the grantor or try to get some other advice to the grantor to make certain that the grantor really understood.

**Mr Winninger:** Under subsection (5) the PGT accepts notification from the advocate that the meeting took place and that the grantor does not oppose the validation.

**Mr Sterling:** I know, but you're talking like these things are easy issues, like one thing happens because an advocate met with this person. If the meeting lasted 30 seconds, then I'd be concerned. If the certificate he's going to issue is extensive, I think the PGT should be concerned that the advocate's interview was a meaningful interview. He might want to ask that question. I don't know, but I'm willing to give him that kind of discretion on the other end of it.

What we're concerned about is that the grantor knows what's happening to him and is advised that he doesn't have to do this and that nobody's pressing him into doing it against his will. That's what we're after and we're asking the PGT to make a determination. I just say why not give him the discretion to make that determination. I've said enough.

**Mrs Sullivan:** My view is that in most cases people will in fact want and welcome the advocate who will sit with them and in a friendly way walk through what will occur in the next steps as the power of attorney is executed and validated.

What I see here is a situation where a person who is already known to be incapable has been assessed by two assessors. That information is in the hands of the PGT. We have an indication that when the person was capable he had a will that the power be granted. The only piece of the entire puzzle the PGT doesn't have is the notification from the advocate that the advocate has explained the situation, conveyed the information and requested an indication from the person that he will or will not want to oppose this. Therefore, the PGT only has the option of refusing, if the advocate cannot get that final last piece. The PGT has no other option than to refuse to validate it.

I give you a situation where the reason for requesting the power is akin to an emergency situation. The PGT here is unable and in fact required to refuse to validate that. The PGT now, in an emergency situation, is going to have no other alternative but to go to court to be appointed as the guardian himself. Then we will still have to go back through another court process to validate the original power for that one little portion, which may be done simply because the person is already incapable, and part of his incapacity may be that he says: "I don't want to do this. I don't want to talk to one more person about anything."

**Mr Winninger:** Just in response, it would appear that you may be referring to an emergency situation where there's a possibility of serious adverse effects. There's another mechanism for that set out in section 59, which we haven't gotten to yet.

**Mrs Sullivan:** But that includes going to court.

**Mr Winninger:** It does, but you can get into court on short notice where circumstances warrant.

**Mrs Sullivan:** Exactly, but you'd still have to go to court on short notice for the PGT to be made the guardian, and then you'd have to go to court latterly with an application to validate the power. Is there any other way—

**Mr Winninger:** Just to come back to Mr Sterling's point, we're clothing the attorney with what could be extremely broad, comprehensive, intrusive powers here, and we feel that the courts should be making those decisions where there's not a consent, especially where an advocate has not intervened.

**Mr Sterling:** I only say that may be the case for what I would call a very serious certificate. If we're talking about a minor certificate, where the attorney or the guardian is given pretty restrictive rights, for instance, that he can order the bathing of a person or something of that

nature, which I would consider pretty minor in terms of being intrusive, we could have to go to court to do that as well.

**Mr Winninger:** You can appreciate, though, the difficulty in trying to draw lines. What may seem minor to us may be of major significance to the vulnerable person. How do you deal with that practically?

**Mr Sterling:** How you deal with it practically is that you try to save the system, you try to save the family and you try to save the court's time and energy on things which we, a collective group, consider reasonable.

**Mr Winninger:** It seems, though, that you're taking, as was pointed out yesterday, the worst-case scenarios, which I guess is the job of the opposition, to keep the government on its toes.

You're saying we should change this section, because in what may be a worst-case scenario, where someone needs immediate attention, he won't see an advocate, yet in most cases the person has already designated a power of attorney and this is just a case of it being validated. In most cases, probably the vulnerable person will welcome the intervention of an advocate and consent to the validation because he chose that person to make decisions in the first place.

But if there are a few individuals who don't want to consent to validation, surely it's appropriate there, since you're about to intrude on their civil and possibly legal rights, that a judge weigh all the evidence on both sides and make a decision that's in accordance with due process. I don't think that's too much to ask to protect the rights of these vulnerable individuals.

**Mr Sterling:** As I understand some of the diseases that are involved and some of the disabilities or the mental illnesses that we may be talking about when we're dealing with these, lucidity comes and goes. As it comes and goes, the cooperation of that grantor is going to come and go, so it depends when the advocate calls. If he calls a month from now, you may force the family into court because lucidity is gone, but if in fact they're lucky and they get in an advocate in a day and the person still is within a lucid period, then he may be able to gain that kind of thing.

What we're trying to do here, in my view, while protecting the interests of the individual to the very maximum, is make it uncomplicated etc with the family, and we're asking the PGT to make the decision. We're putting some great faith in what an advocate is going to say or not say to this individual. When he sends this note to the PGT, it's supposed to be some great amount of advice that this individual has received. Even after he sends the note, all of the clauses are permissive. They don't say he "shall" issue the certificate; it says he "may."

You're still giving the PGT discretion, which I think is right, but if you're going to give him discretion, why are you saying that this particular process, ie, the meeting with the advocate, must take place if the PGT is satisfied that particular part of the process can in fact be replaced by something else which is equal to or better in terms of determining what are the real wishes of that person?



**Mr Winninger:** I don't have anything to add, Mr Chair, to this debate because I'd just be repeating myself.

**Mr Sterling:** Yes, I think we're just going around in circles.

**Mr Wessinger:** Just to make a comment, I think the Liberal amendment unfortunately doesn't provide protection, because even if we were going to make a simpler procedure, at a bare minimum you would have to have required evidence of proof of service of the application on the individual. That isn't in the Liberal motion, so I don't see how we could support it, because it would detract too much from the rights and I think it would be contrary.

Without notice, I think we'd have very major problems from a legal point of view. Also, we can't go to the extent of giving the public guardian and trustee a discretion because that might be considered unconstitutional, if I remember my law correctly.

**The Chair:** Further discussion?

**Mr Sterling:** It is discretion, isn't it?

**Mr Wessinger:** No, it's not discretion here. It's just the "shall," I believe.

**Mr Sterling:** No, it says "may."

**Mr Winninger:** It says "shall" for applying to court if he refuses to validate. That's where the "shall" appears.

**Mr Sterling:** But I mean in terms of issuing the certificate, it says he may.

**Mrs Sullivan:** Yes, that's right.

**The Chair:** Further discussion?

**Mr Sterling:** I'm ready to vote.

**The Chair:** Seeing no further discussion, we'll proceed to the vote on the Liberal motion on subsections 49(6) and (7). All those in favour? Opposed?

Motion negatived.

**The Chair:** We had a fairly lengthy discussion on there. I think we could use a 10-minute recess.

The committee recessed at 1524.

1542

**The Chair:** I call this meeting back to order. We'll now go to the Liberal motion on paragraph 50(2)4.

Mrs Sullivan moves that paragraph 4 of subsection 50(2) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by adding at the end "and to detain and restrain the grantor in that place during the care or treatment."

**Mrs Sullivan:** This is an additional—I shouldn't say additional—a completion of the thought, I believe, that's included in subsection (4), which would enable the attorney, subject to certain conditions, to take the grantor to the place for care or treatment but doesn't include the right to ensure that the person stays there during the course of that care or treatment. That's the reason for the inclusion of this amendment.

**Mr Winninger:** We find that to be an acceptable refinement on the wording in paragraph 50(2)4 and therefore we'll be supporting the amendment as well.

Motion agreed to.

**The Chair:** Now we'll go to the Liberal motion on clause 50(6)(b).

Mrs Sullivan moves that clause 50(6)(b) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by striking out "capable of personal care" in the third line and substituting "capable of giving a power of attorney for personal care."

**Mrs Sullivan:** I think there was a drafting error in this section. Earlier I mentioned, when we included an amendment indicating that a person could have capacity to give a power for personal care, that the person didn't have to be capable of that personal care. There was confusion there. I think this is a drafting problem rather than a problem, so that's why I'm trying to correct it.

**Mr Winninger:** We certainly see the wisdom of that amendment. It's also in accord with an earlier amendment that was moved by the Liberals to section 47.1, indicating that you don't have to be capable, necessarily, of personal care. Therefore, we're supporting this amendment.

**Mr Sterling:** I'm always glad to see the opposition correct the errors of the government, so I will vote for this motion.

**Mr Winninger:** You couldn't let that go by graciously. Motion agreed to.

**Mrs Sullivan:** Mr Chairman, I'm withdrawing clause 50(14)(b).

**The Chair:** Thank you. Okay, government reprint, clause 51(1)(a). Agreed? Carried.

Government reprint, clauses 51(1)(c) and 51(1)(d). Agreed? Carried.

Government reprint, subsection 51(3). Agreed? Carried.

Next, we go to the Liberal motion on clause 56(2)(f).

**Mrs Sullivan:** I'm going to stand this amendment down following discussions with the parliamentary assistant and counsel who, I understand, like the intent of the motion; however, just feel the issues that are included would better be included in specific parts of the bill. So I'll stand this one down and we'll come back to it.

**Mr Winninger:** Agreed on that.

**The Chair:** Government motion on clause 56(4)(c). Mr Winninger, would you care to move that?

**Mr Winninger:** Yes, I will.

**The Chair:** Mr Winninger moves that clause 56(4)(c) of the bill, as reprinted to show the amendments proposed by the Attorney General, be struck out.

**Mr Winninger:** We feel the guardian should not be clothed with the power and authority to give consent on the person's behalf to the use of restraint, confinement or electric shock for the purpose of aversive conditioning. We understand that the need for aversive conditioning is very limited. We understand furthermore that there is great repugnance, as expressed in the presentations to the committee, that the use of electric shock is still being used occasionally for aversive conditioning. We feel this power is just too objectionable to give to a guardian, and for that reason we're seeking to delete it. There is a later consequential amendment to follow.

**Mr Sterling:** To tell you the truth, I don't know how to assess this latest move with regard to the government withdrawing the section. I guess I object, not from the standpoint of the merit of either having it in or out, but from the standpoint of doing it at this late date, when we've had many health care providers in front of us who might well have commented on the section. Seeing it withdrawn at this late date in this process, quite frankly, I'm not able to vote on this with any degree of knowledge as to what the medical profession would say either in favour of or against the withdrawing of this section. I guess what I'm doing is in a vacuum. I only wish the government had expressed its intention to withdraw this at an earlier date.

1550

**Mr Winninger:** Just to add to what I said earlier, there has been some informal consultation with the people who still administer this therapy, if you can call it that, on a limited basis and it would appear that they don't have any great resistance to not utilizing that therapy in the future.

I might add that this is not a form of treatment. There are other restraints available to people who deal with people who may require such restraint. But there seems to be a growing antipathy and aversion to the use of such conditioning and for that reason we feel it's appropriate that the guardian not be clothed with authority to authorize the use as a substitute decision-maker.

**Mr Sterling:** I was quite upset to hear the testimony of one of our witnesses, a psychiatrist, who suggested that self-inflicted mutilation was a necessary part of her treatment process of people who were sick and whom she was treating. I always feel uncomfortable when we're dealing with sections dealing with medical treatment without expert advice in front of the committee.

I will support the motion, but as I say, I feel it's quite inappropriate to do this at this time.

**The Chair:** Thank you, Mr Sterling. Further discussion? Seeing none, we'll proceed to the vote.

All those in favour of the government motion on clause 56(4)(c)? Opposed?

Motion agreed to.

**The Chair:** Next we'll go to the government reprint on subsections 56(5) and (6).

**Mr Winninger:** One of those is a deletion—56(6).

**The Chair:** Agreed? Carried.

**Mrs Sullivan:** It's been pointed out that an identical situation that's been included in two of my amendments with respect to replacing the words "capable of personal care" and substituting "capable of giving" a person "a power of attorney for personal care," exists in subclause 51(3)(b)(ii). I know we've passed that section, but I wonder if we can just go back to take care of it.

**Mr Winninger:** To which section?

**Mrs Sullivan:** Subclause 51(3)(b)(ii) on the top of page 31.

**Mr Winninger:** Yes, I think we could consent to reopen that.

**Mrs Sullivan:** We have various opinions on whether this is appropriate or not, so I'll stand this down and, at an appropriate time, we'll open it if it is appropriate. Figure it out, Steve.

**The Chair:** Thank you.

**Mr Winninger:** I think in section 51 we're talking about terminating a power of attorney for personal care where the grantor resumes capability for personal care. So it would seem appropriate there, but we'll hear from our counsel.

**The Chair:** Okay, government amendments? Subsection 57(3).

**Mr Winninger moves that subsection 57(3) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by striking out "subsection 56(2)" in the third line and substituting "subsections 56(2), (3), (4) and (5)."**

Discussion?

**Mr Winninger:** If the Chair will permit me a moment, I can share the rationale for that amendment with you. As it currently exists, there is a problem in subsection 57(3). It would appear that a temporary guardian could not be given the powers that a court can give under subsections 56(3), (4) and (5). There seems to be no reason to preclude a temporary guardian from being given these powers in some circumstances.

Accordingly, it should be possible for a person who has partial guardianship and custodial authority to exercise the power to apprehend, as provided in subsection 56(3), or to consent to the person's admission to a psychiatric facility under subsection (4), and to be given the power to exercise the subsection (4) powers from time to time. So the change is to amend the subsection by adding, after "56(2)," "(3), (4) and (5)."

**Mr Sterling:** I can see (3), but I don't understand (4) and (5).

**Mr Winninger:** Could you give me a moment to confer with counsel.

Just in answer to Mr Sterling's question, we feel that the temporary guardian ought, in addition to subsection (2), to have the powers provided in subsections (3), (4) and (5) and that's why those would be added under section 57.

1600

**Mr Sterling:** I don't see any powers in (4) and (5).

**Mr Winninger:** Of section 56?

**Mr Sterling:** Yes.

**Mr Fram:** It's to admit to a psychiatric—

**Mr Sterling:** That's (3).

**Mr Winninger:** Wait a minute. What we're doing in (4) in particular is importing the restrictions that apply to a permanent guardian into the section that governs temporary guardians, and the same subsection (5) allows an order that can specify powers that may be exercised from time to time. Basically, we're extending powers to the temporary guardian that the permanent guardian currently would enjoy.



**Mr Wessinger:** We're not talking about temporary guardianship here. Aren't we talking about partial guardianship?

**Mr Winninger:** Partial. Sorry.

**Mr Wessinger:** Okay, I just wanted to clarify that.

**The Chair:** Further comments? Seeing none, we'll proceed to the vote. All those in favour of the government motion on subsection 57(3)?

Motion agreed to.

**Mrs Sullivan:** Mr Chairman, I also have an amendment on subsection 57(3), but I would like counsel's advice as to whether, with the government motion, my motion is now redundant.

**Mr Fram:** Yes.

**Mrs Sullivan:** It is. So you've covered what I had in mind. Okay.

**The Chair:** Okay, no need to withdraw.

**Mrs Sullivan:** I haven't read it in, so I don't have to withdraw it.

**The Chair:** Next, the government reprint on subsection 59(1). Agreed? Carried.

Next, on the PC motion, subsection 59(4).

Mr Sterling moves that subsection 59(4) of the bill, as reprinted to show the amendments proposed by the Attorney General, be deleted and replaced with the following:

"(4) Notice of the application shall be served on the person alleged to be incapable, and his attorney for personal care, if known, unless the court dispenses with notice in view of the nature and urgency of the matter."

Discussion?

**Mr Sterling:** It adds not only "the person alleged to be incapable" but that if there's an attorney for personal care, then that person should be notified of the application as well.

**Mr Winninger:** Perhaps I can have a moment to confer with counsel. I think that's a very reasonable amendment and we'll be supporting it.

**The Chair:** Further discussion? Agreed?

Motion agreed to.

**The Chair:** Government reprint subsection 59(12). Discussion? Agreed? Carried.

Government reprint subsections 63(3) and (3.1). Discussion? Agreed? Carried.

Next we go to government reprint subsections 63(4.1) and (4.2). Agreed? Carried.

Next we go to a government motion on clause 63(7)(b).

Mr Winninger moves that clause 63(7)(b) of the bill, as reprinted to show the amendments proposed by the Attorney General, be struck out and the following substituted:

"(b) The practice is consistent with the guardianship plan."

**Mr Winninger:** As it stands, clause 63(7)(b) regulates the right of a guardian or attorney to consent to the use of confinement, restraint and monitoring devices. For private guardians it requires that the consent be in conformity to the guardianship plan. However, if the guardian or attorney

is the public guardian and trustee, the practice needs only be consistent with the public guardian and trustee's policies. The advocacy coalition objected to the existence of different standards, and we would suggest that the public guardian and trustee would have a specific guardianship plan for each person it acts for anyway, and therefore it seems appropriate that there be a guardianship plan for the PGT as well.

**Mrs Sullivan:** I think in another section of the act the PGT is precisely excluded from the requirement of having a guardianship plan.

**Mr Winninger:** We took it out. That was one of the deleted sections.

**Mrs Sullivan:** How about that; snuck it in.

**Mr Winninger:** We snuck it out.

**The Chair:** Further discussion?

**Mr Sterling:** Is it reasonable? I mean, is it necessary that each individual have a guardianship plan that is under the care of the guardian if there are policies or whatever as to what—all that's going to happen is you're going to transfer the general policy to the particular individual—is it necessary to pull out various paragraphs in order to do it?

**Mr Winninger:** People who presented suggested you shouldn't have two standards, one for the PGT and one for the private guardian. Since it's not onerous for the PGT, who probably already has a guardianship plan, why not formalize the requirement for that so you have the same consistent standard applying to both the private and the public guardian?

1610

**Mr Sterling:** I would think the PGT has more accountability than the private guardian, whether you want to admit it or you don't want to admit it. So I can see a difference for the standards.

**Mrs Sullivan:** In speaking to this particular amendment, it raises the entire issue of all the new requirements of the entire public guardian and trustee operation. This is becoming more and more of a concern. I think if you look through the act and do a rough count, there are about 40 new mandated obligations to the PGT than currently exist.

Frankly, I had missed the fact that in the earlier section we were eliminating the provision that the PGT does not have to have a guardianship plan. So in fact what we've done is added another obligation of the PGT in its operations. I suppose now we have to deal with the questions and ask what will be the extent of funding and staff to meet the other obligations of the PGT. I can do this here.

There are other areas of the bill where I want to raise these same issues, but what is the government's intent with respect to funding of the PGT and what is the government's intent in terms of funding the preparation for the implementation of this bill? Have you flowed money already in terms of preparation? What money do you intend to flow to deal with all these new requirements?

**Mr Winninger:** It seems to me this question has arisen before and the answer was given that money hasn't flowed yet and doesn't need to flow yet, but decisions will

have to be taken as to what the cost consequences are of implementing the provisions of this legislation and it's appropriate that this be done.

**Mrs Sullivan:** Have you done a complete analysis of all the implications of the new provisions of this bill on the PGT, first of all, the costing, the requirements for additional staffing? When my office has anything to do with the trustee or the guardian's office, I'll tell you, they are really short-staffed now and probably underfunded. What are you looking at in terms of cost on full implementation here and what kinds of costs for the lead-up period to implementation? This isn't going to happen overnight, and now we have another mandated responsibility.

**Mr Winninger:** I know the public trustee's office has been following these proceedings closely and will make the appropriate submissions.

**Mrs Sullivan:** But you haven't done any analysis.

**Mr Winninger:** I'm not sure what you mean by "analysis."

**Mrs Sullivan:** Do you know how much this is going to cost? Do you know how many staff people are going to be needed?

**Mr Winninger:** There are decisions being made now as to—

**Mrs Sullivan:** What are your estimates?

**Mr Winninger:** I don't have those estimates here today.

**Mrs Sullivan:** I might have known.

**Mr Winninger:** Why did you ask?

**Mrs Sullivan:** Because frankly, I think the public's entitled to that information, and so are we as legislators. That's why I asked.

**Mr Winninger:** I'm confident that sufficient resources will be provided to implement this legislation.

**Mrs Sullivan:** I suggest to you that if sufficient resources, about which you apparently have no information, aren't allocated, this thing is going to be a monumental balls-up.

**Mr Winninger:** I would expect that would provide more grist for your mill.

**Mrs Sullivan:** Or more things to change when the government changes.

**The Chair:** On the government motion, clause 63(7)(b), further discussion? Seeing no further discussion, we'll proceed to the vote. All those in favour of the government motion on 63(7)(b)? Opposed?

Motion agreed to.

**The Chair:** We now go to the Liberal motion on subsection 63(7.1).

Mrs Sullivan moves that subsection 63(7.1) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by striking out "in emergencies" in the third line.

**Mrs Sullivan:** This amendment is presented because the common law duty of care gives to restrain or confine persons is not limited to emergency situations, and if in

fact the intent is to reflect the common law here, this change must be made. In fact I think in another part of the bill we talk about ongoing situations of delivery of health care.

**Mr Winninger:** We accede to your motion, particularly in light of the following wording after "in emergencies," which provides "as may be necessary to prevent serious bodily harm to them or to others." We think the situations are adequately limited by that phrasing and that deleting "in emergencies" would not take away from the section. Therefore, we would support your amendment.

**The Chair:** Further discussion? Seeing none, we'll proceed to the vote. All those in favour? Agreed?

Motion agreed to.

**The Chair:** Government motion, subsection 63(7.1.1).

Mr Winninger moves that section 63 of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by adding the following subsection:

"Electric shock

"(7.1.1) The guardian shall not use electric shock as aversive conditioning and shall not give consent on the person's behalf to the use of electric shock as aversive conditioning."

**Mr Winninger:** This is the consequential amendment—

**Mrs Sullivan:** We don't have a copy.

**Mr Winninger:** Oh, I was advised by the clerk that copies have been circulated.

**Mr Sterling:** It could be possible. The pile is getting a little deeper and thicker.

**Mr Winninger:** Yes. You don't have 63(7.1.1)?

**The Chair:** Perhaps we can stand it down until we get copies. Do I have unanimous consent to stand that one down? Agreed.

Next we go to a Liberal motion on 63(7.2) and (7.3)

Mrs Sullivan moves that subsections 63(7.2) and (7.3) of the bill, as reprinted to show the amendments proposed by the Attorney General, be struck out.

1620

**Mrs Sullivan:** I've moved this because frankly I feel that these issues are better included in the Consent to Treatment Act, where in fact they are included, and the provisions with respect to these issues, the issues of research and sterilization, should best be covered within that bill and solely within that bill.

In my view, our discussions related to providing consent for research were inadequate, and I would hope that we will, within a reasonable period of time and after some further consultation, be able to develop other protocols that are statutory with respect to providing consent to research.

It seems to me that the place for all these restrictions and statutory requirements with respect to consent in these areas should be in the Consent to Treatment Act, because the care givers, whether the attorney or the guardian, in fact must provide consent in accordance with that act. I think there's almost a redundancy here, but I think it's more appropriate that it be included only in the Consent to Treatment Act.



**Mr Winninger:** Mr Wessenger may have something to add to this since he's steering Bill 109, but I think it's quite clear, based on several presentations by I believe it was the University of Toronto Centre for Bioethics, that the common law was quite well developed as to when research activities could be carried out and what kind of consent is required for that, and further for sterilization and removal of regenerative tissue.

I think it's important that we retain these two sections in here so it's abundantly clear that the substitute decision-maker is not being clothed with authority to make decisions on behalf of individuals that involve the objectives in these two subsections. I think it's very appropriate that they be placed here and in this particular section because it clearly sets out that a guardian's powers and authority do not extend to decisions of this kind.

**Mr Wessenger:** I might just add that certainly I would have grave concern about the deletion of these sections because of the concern that if they are not left in, it is quite possible that a guardian might consent to some of the procedures mentioned in (7.2) or (7.3) and we want to ensure beyond any doubt that this consent will not result in authorizations which are presently not authorized under the common-law situation.

**Mrs Sullivan:** But they're already limited or they will be limited by the provisions of the Consent to Treatment Act, which in fact is broader in delineating the circumstances and the responsibilities of the substitute decision-maker and includes these but other responsibilities as well.

It seems to me that if you include these responsibilities, you're going to have to include all the other obligations on the substitute decision-maker also within this bill, rather than leaving the protocols for the substitute decision-maker's decision-making in the one bill and that becomes the reference.

**Mr Wessenger:** Certainly the advice I've received from legal counsel was that it was important that these provisions remain in this bill. Unfortunately legal counsel is not here today to respond and unfortunately I wouldn't have time to do the analysis just myself today to respond to the question, but certainly it's been well indicated to me that these were important to remain in both bills.

**The Chair:** Further discussion? Seeing no further discussion, we'll move to the vote. All those in favour of the Liberal motion on 63(7.2) and (7.3)? Opposed?

Motion negatived.

**The Chair:** Possibly we can go back to the government motion on subsection 63(7.1.1), now that it has been distributed. I'll give everybody a moment to read it. Mr Winninger, any comments?

**Mr Winninger:** As I was saying earlier, it's a consequential amendment to the amendment in clause 56(4)(c) which would prohibit a guardian from making decisions that would entail the use of electric shock on vulnerable people or consenting on that person's behalf to the use of electric shock as aversive conditioning.

I would just reiterate many of the submissions that were made in regard to the cattle prod issue and the strong

repugnance that was indicated that this kind of aversive conditioning could still exist.

Given its limited nature and given the fact that there are many alternative forms of therapy available, it will not be diminishing in any substantial way the authority of guardians to deal with vulnerable people.

**Mr Sterling:** I make the same argument as I made before. I think any layman would find this kind of treatment repugnant, but as I said before, when I heard the evidence of another witness talking about a completely different kind of thing, somebody who knew a lot more about treating psychiatric disorders than I talking about defending self-infliction of injury as a necessary kind of behaviour, I am saying it is not proper for the government to bring forward amendments that really require expert testimony at a late date like this.

I guess I find it particularly offensive in that in my view it is something which attracts probably much more public attention and is more related to media and that kind of thing than it is to the real problems we face and are dealing with in this bill. Notwithstanding that, it leaves opposition members in a very difficult position because we have not heard any expert evidence on this. There was no notice that this was going to be considered an issue in this bill.

The parliamentary assistant knows my position because he asked me two nights ago about introducing such an amendment. I said to him at that time I didn't think it was right for him to bring an amendment which probably would have the approval of the medical profession and health care professions, but I don't know. I'm again voting in a vacuum. I think that legislators don't do themselves any favours by voting on matters where professions should have the opportunity to have their input. All I can say is I think it's wrong to do this at this juncture without that kind of expert evidence.

1630

**Mrs Sullivan:** I have very similar concerns to those expressed by Mr Sterling. The medical profession is now approaching the procedures, courses of treatments and the analysis of the appropriateness of their use in various circumstances in a far more scientific way than had been the case, say, earlier in this century or even 10 years ago.

For example, we've seen the very extensive analysis in the Scott report of the appropriateness of certain therapeutic interventions in the treatment of various situations, the use of laboratory examinations, laboratory tests. In fact, we have not seen or heard or had available to us that kind of expert analysis, nor is it my understanding that that request for the analysis has been made from the profession itself with respect to these procedures which are summarily being withdrawn as a matter of policy by the government.

Without that kind of expert advice as a matter of policy, we could have a surprise amendment saying that the guardian can't accede to the use of certain other medical procedures that the government doesn't approve of, and the restriction on that may be because of cost, not because there has been expert advice. The government could say,

"We're not going to allow any more substitute decision-making on CAT scans or on access to certain highly expensive procedures." This is quite arbitrary.

As an individual citizen, I understand and am very sympathetic to the concerns that have been raised about electroconvulsive therapies, but we have not heard from the medical profession in an expert and analytical way its opinion of banning that in its entirety. They may say this is very good and they may not need extensive analysis to say this is appropriate. On the other hand, they may say there are certain protocols that should be used in terms of the use of electric shock.

Working here with a surprise amendment in this area and in association with the other amendment, we are opening ourselves up to a kind of Big Brother determination that certain procedures are acceptable on the basis of policy or on the basis of cost and certain others are not. So I have real problems with this, for very similar reasons.

**Mr Winninger:** By way of clarification perhaps, and maybe Mrs Sullivan is already aware of this, we're not addressing the issue of electroconvulsive treatment here. That's another issue perhaps for another statute and another day. We are dealing with an aversive response contingent shock here.

There are, we're aware, alternative aversive therapies available that involve the use of different kinds of restraint, punishment or loss of privilege, including differential reinforcement of incompatible behaviour, compliance training and functional independence training. Strong claims are made for that form of therapy.

We're not precluding the use of psychotropic drugs and we're advised that where such aversion is currently being used, it's combined with psychotropic drugs in any event. So we feel there are many different alternatives available here and that, given the apparent nature of shock, we need to include a prohibition. That's what we're doing in this subsection.

**Mr Wessinger:** I'd just like to add that I don't see this amendment as relating to treatment anyway. It's an amendment relating to human rights. I think it's a concern that human beings are treated like cattle, and that's the concern of the use of the electric shock in this instance. That's what it's trying to address: the human rights issue and not the treatment issue.

**Mr Sterling:** I just want to say that I object to Mr Winninger saying that we are aware of other treatments because we, the committee members, are not aware of anything about this issue. That was the whole point I was making.

**The Chair:** Thank you. Further discussion? Seeing none, we'll proceed to the vote on the government motion on subsection 63(7.1.1). All those in favour? Opposed?

Motion agreed to.

**The Chair:** I'll go back to the government reprint on 63(7.1) to (8) as amended.

**Mr Winninger:** There is a Liberal motion that affects (7.3), so we may have to deal with that first.

**The Chair:** Where's that?

**Mr Winninger:** Or have we already voted on that?

**The Chair:** That's been done.

**Mr Winninger:** Yes, that's right. We came back. I'm sorry.

**The Chair:** On the government reprint, as amended, on (7.1) to (8). Discussion?

**Mr Sterling:** Okay, you're just going through—

**The Chair:** We're backing up on the government reprint. Any discussion? Seeing no discussion, all those in favour of the government reprint, subsections 63(7.1) to (8)? Agreed? Carried.

Government reprint, subsection 64(2.1)? Agreed? Carried.

Government reprint, subsection 65(1).

**Mr Winninger:** It's a deletion.

**The Chair:** It's a deletion. Discussion?

**Mrs Sullivan:** We're at subsection 65(2) now?

**The Chair:** No, subsection 65(1). It's a deletion. Agreed? Carried.

Okay. Subsection 65(2), a Liberal motion.

Mrs Sullivan moves that subsection 65(2) of the bill, as reprinted to show the amendments proposed by the Attorney General, be struck out.

1640

**Mrs Sullivan:** This amendment is put forward to deal with circumstances where, because of the nature of the person's illness, changes may be necessary. The change that could be contemplated in this section may be, by example, within a nursing home or within a hospital. That change may be to a more restrictive setting or even a move into a nursing home, and could not be done in the case. So we've just asked that this section be struck.

**Mr Sterling:** A "guardian of the person": Whom does that include? Does that include just the guardian who is operating under a validated power of attorney? Does it include a person who's acting as an attorney for personal care?

**Mr Winninger:** We'll let Mr Fram address this.

**Mr Fram:** According to section 66, "Sections 63 to 65," which this is, "also apply with necessary modifications to an attorney under a power of attorney for personal care that has been validated." So it applies to all validated attorneys. Then, "Section 63, except subsection 63(8) and (9), applies with necessary modifications to an attorney acting under subsection 47(9)."

**Mr Sterling:** I hope everybody makes a power of attorney and all the rest of it, but what happens is that it will probably still be 80% to 90% of the cases where people haven't made a power of attorney and it's the kids who are making the decision about mom or dad going from the fifth floor to the second floor of a nursing home, where he or she has a little more security, because there's been a deterioration in the capability of—what happens in that situation?

**Mr Winninger:** I'll let Mr Fram continue with his answer on this one.

**Mr Fram:** Under section 65, the guardian, including those persons, would have to get the consent of the public



guardian and trustee to move him or her to a more restrictive setting.

**Mr Winninger:** We have our own amendment to follow and it—

**Mr Sterling:** Yes, I saw the amendment. It is a little easier than the existing subsection 65(2). Instead of getting permission, if you're not willing to accept the deletion of it, wouldn't it be a better thing to have just some kind of notification and then let the public guardian take a positive action, if he decided, so that there's not a delay, there's nothing—

**Mr Winninger:** I realize our amendment, subsection 65(3), is not officially before you right now, but does not that amendment address your concern?

**Mr Sterling:** Why are we burdening the public guardian and trustee in family situations that are—there have probably been 200 decisions like this made today across Ontario where Alzheimer's disease has progressed to such a state that they have to take grandma off the fifth floor, put her down on the third floor, and the corridor doors to the balcony are locked on the third floor. Who are we trying to protect here? Are we really protecting anybody in this?

**Mr Winninger:** Aren't we simply providing a safeguard in a situation where it may be that certain rights will be taken away from the individual?

**Mrs Sullivan:** I really think the entire section should be struck out. Whether you are an attorney operating under a power of attorney, whether you are a guardian, whether you are a statutory guardian or whether you are the public guardian, we have now a guardianship plan already filed. We have the power of attorney file. Now we are going back to the PGT to ask permission to do what we are supposed to be doing.

This would, by example, mean that for a person who is being cared for at home, with some attendant care perhaps, or by the family, permission would have to be obtained from the public guardian and trustee when the family member who happens to be the statutory guardian says: "I can no longer provide that care and I need the nursing care to ensure that my parent is being looked after appropriately. I cannot do the tube feeding," or whatever; or if that person is already within a nursing home or hospital setting and must move from an area that is open to an area that may be more restrictive, because the floor is closed or there are other security measures, so the Alzheimer patient can't be found six miles from the place, or where those restrictive settings may include things like security people.

I just think it's absolute nonsense to say we have to have permission once we have a validated power of attorney or once we've been named as guardian. Why do we need additional permission?

**Mr Winninger:** Maybe I can help shorten things by saying that you make some plausible arguments. Perhaps if we call a five-minute recess, we might be able to resolve this issue.

**The Acting Chair (Mr Stephen Owens):** Do we have consent for a five-minute recess? Agreed. The committee is adjourned for five minutes.

The committee recessed at 1648.

1702

**The Chair:** I call this committee back to order. We've received a response from the House leaders and it states:

"Dear Mr Cooper:

"Thank you for your letter of September 3, 1992. The House leaders have agreed to alter the order of the House to allow amendments to be filed until 4 pm on September 16, 1992.

"Sincerely,

"Dave Cooke, Ernie Eves and Murray Elston."

**Mrs Sullivan:** I guess we'll be here until 3 o'clock in the morning that night too.

**The Chair:** Quite possibly.

**Mr Sterling:** What day is that?

**The Chair:** It's a Wednesday.

**Mr Sterling:** I'm busy that night.

**The Chair:** I'm sure you'll have the appropriate substitution slip in.

Further discussion on subsection 65(2), the Liberal motion?

**Mr Winninger:** We've certainly had an opportunity to reconsider our position in this matter, and in order to maintain the spirit of cooperation that's characterized these proceedings thus far, we'd be prepared to accede to the Liberal motion.

**Mrs Sullivan:** We appreciate that.

Motion agreed to.

**Mr Winninger:** We'll withdraw the next government motion for subsection 65(3).

**The Chair:** Subsection 65(2)? You've struck out—so on the government reprint, subsection 65(2).

**Mr Winninger:** On the government reprint, yes, that would be struck out, and we're withdrawing our motion.

**Mrs Sullivan:** Are we at section 66 now?

**The Chair:** No. You're withdrawing subsection 65(3)?

**Mr Winninger:** Yes, we are.

Could I just have the floor for a moment to note something for the benefit of legislative counsel? There'll have to be a consequential amendment to section 66 as a result of our vote on the earlier section.

**The Chair:** Okay, thank you. Now we go to the government reprint 70(1). Agreed? Carried.

Government reprint subsection 70(4). Agreed? Carried.

**Mrs Sullivan:** I'd like to move back to section 68 for a clarification. This is in respect to the application to appoint a guardian of property. Paragraph 68(1)(c)1 requires that the public guardian and trustee certify that he "has assessed the proposed guardian."

I'm very concerned about the use of the word "assess" here because the sense of the word "assess" in this bill relates to an assessment of capability. I don't believe that is

what the guardian should be doing. I think we should have a change here. I could make the change or the government could make the change, but I think we need a change in that word.

**Mr Fram:** Yes, that should be “considered the appropriateness.”

**Mrs Sullivan:** Yes.

**Mr Winninger:** Sorry, I was just having a conversation with legislative counsel about an earlier section, but we admit here that there’s a misprint or at least a mistake.

**Mr Fram:** It should be “considered the appropriateness of the proposed guardian.”

**Mr Winninger:** Perhaps we could stand this down and make the required change to the subsection.

**Mrs Sullivan:** I don’t have a motion yet. We can bring one, but I wanted to raise it because I think there’s a problem there.

**The Chair:** Thank you. Now we’ll proceed to government reprint 71(1). Agreed? Carried.

Government reprint 71(3). Agreed? Carried.

Government reprint 72(1) Agreed? Carried.

Government reprint 73(1). Agreed? Carried.

Government reprint on the French version 74(1). Agreed? Carried.

**Mr Owens:** You didn’t want to read that?

**Mr Winninger:** It doesn’t need to be read.

**The Chair:** Okay, PC motion on clause 75.1(1)(e).

Mr Sterling moves that subsection 75.1(1) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by adding the following:

“(e) attorneys under powers of attorney for personal care that have been accepted for registration under section 50, and subsequently recorded in the register under (d), which have been revoked.”

**Mr Sterling:** I think the reason for this is to know who’s been in charge in the past and perhaps, for some reason, why that person shouldn’t be reintroduced as the power of attorney for personal care in the future. I think that’s the reasoning behind it.

**Mr Winninger:** I don’t quite understand the reason for the amendment, but if Mr Fram does, perhaps he could clarify whether or not it’s required.

1710

**Mr Fram:** Subsection (4) of this section says, “The public guardian and trustee shall update the information contained in the register whenever he or she receives new information referred to in subsection (3).” Now, since that would be a person who would be an attorney under a power of attorney for personal care that would be in the register that would be validated or registered powers of attorney, if the information was that this authority was terminated or changed, then the register, it would seem, would reflect that. So I don’t see what he is attempting to do.

**Mr Sterling:** I think the reason I put it in was this: If there was an impression that there was a power of attorney for personal care out there and that it had been validated,

and a relative came in to a health care provider and said, “Phone the PGT and find out about this validated power of attorney,” and the validated power of attorney had in fact been revoked, how does the health care provider try to chase down who’s responsible or who he can go to to try to make a decision?

**Mr Winninger:** Are you talking about the same relative for which the power was revoked or another relative inquiring into whether a power had been revoked?

**Mr Sterling:** I’m talking about the health care provider and really knowing what’s gone on.

**Mr Winninger:** If subsection 75.1(4), which requires the PGT to update the information, doesn’t answer your concern, why wouldn’t you seek to add further amendments to subsection (1) for all of those, for example, attorneys who have been validated under sections 49 or 50?

**Mr Fram:** I’m unclear as to what problem we’re solving. If the question at the treatment facility is, “Does X have a validated power of attorney or a power of attorney that’s registered?” the answer can be obtained from the public guardian and trustee’s register. If the question is, “Does he now have or has he ever had a validated power or registered power?” the answer won’t be found in the register. That’s the answer that the—it’s sort of like all of these information questions: “Do you allow it to lie there and be publicly accessible, even though there’s no validated power now or registered power now?” The answer here is no, and it’s probably because that information itself is not vitally needed by anybody.

**Mr Sterling:** I don’t see the difference under sections 49 or 50, and I’m not sure why I just put section 50 in there. I’m trying to remember what the Canadian Bar Association said about this, so I’m only speculating.

The only other concern you might have is that if there wasn’t any power of attorney validated at that time, and a relative came in who said, “I think you should do this or that,” and it had been revoked with the selfsame relative, then the health care provider would be, I guess, guarded in terms of taking advice from that relative or that person. I think that might have been the rationale behind it.

**Mr Owens:** Norm, are you maybe looking at something around time sensitivity, like how long it takes for the information to be transferred to the register so that it would be available to institutions?

**Mr Sterling:** No, it’s not the time thing. I think it was the latter concern that I just expressed, and that is that sections 49 and 50, validated powers of attorney—we’re talking about the more extreme situations under those kinds of powers of attorney, where you’re giving the attorney some heavy responsibilities and that kind of thing. The health care provider who is having to make a decision about the treatment is going to be, in the absence of a power of attorney, or even if there was an application—I guess the PGT would tell then. I would assume the PGT would still know that there was a former revoked power of attorney.

**Mr Fram:** That wouldn’t be part of the register. There are all sorts of information that could—when somebody



comes in and claims authority under the Consent to Treatment Act, there are certain safeguards in there—that the person isn't in conflict and sees no reason why the person would object to his or her making the decision. There are all sort of things. A revocation by itself may simply mean the person thinks he's not going to have any more spells, he has full capacity and it's not a difficulty between himself and the attorney. So we really don't know why.

**Mr Sterling:** I'm going to have to withdraw the amendment at this time. Maybe the clerk can get me the CBA brief so that I can have an opportunity to re-read it.

**The Chair:** Would you like it withdrawn or stood down?

**Mr Sterling:** Perhaps you could stand it down until I have an opportunity to look at the brief.

1720

**The Chair:** Do we have unanimous consent to stand this one down? Agreed.

Okay, Liberal motion on subparagraph 75.1(3)2i.1.

**Mrs Sullivan:** I'm not going to put forward that motion, Mr Chair.

**The Chair:** Thank you.

Government reprint, subsection 76(1). Agreed? Carried.

Government reprint, subsection 76(2). Agreed? Carried.

Government reprint, subsections 76(3) to (6). Agreed? Carried.

Government reprint, subsections 77(1) and (2). Agreed? Carried.

Government reprint, subsection 78(1). Agreed? Carried.

Government reprint, subsections 78(2) to (6). Agreed? Carried.

PC motion on subsection 79.1(7).

**Mr Sterling:** I'm told by legal counsel that this is the legal status. All it does is state what happens anyway, so I'm going to withdraw that.

**The Chair:** Thank you.

Mr Sterling moves that section 80 of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by adding the following:

"80..., except in those circumstances where an alternate mechanism for arbitrating disputes is set out in a power of attorney."

**Mr Winninger:** It seems to me on the surface that this is unobjectionable but not required. If the process of arbitration is set out in the power of attorney, essentially you'd be empowering the individual grantor of the power of attorney to determine how disputes will be resolved. We don't necessarily think it's necessary, but I don't think there's any harm in it either. I'll let Mr Fram speak to that as well.

**Mr Fram:** You'll note that the public guardian and trustee is only given a duty to attempt to mediate. If the parties themselves don't want to mediate or they have another alternative, then the provision would be useless in any event.

**Mrs Sullivan:** No, it says "shall mediate."

**Mr Fram:** That's right, and "mediate" means to get people to agreement, if you don't get past, "We've got an arbitration provision" or "Go, my child, with blessings."

**Mr Winninger:** We're all agreed, I think, that the mediation is not binding; it's non-binding.

**Mr Sterling:** But the power of attorney might provide for a binding mechanism.

**Mr Fram:** There's no harm in it. I don't think there's any harm in the amendment; I just think it's unnecessary.

**Mrs Sullivan:** Agreed.

**Mr Winninger:** Agreed what? That we're cluttering up the act with unnecessary provisions?

**Mrs Sullivan:** I think if it doesn't cause harm, it may in fact improve it for some people in some circumstances. If a mother has given a power of attorney that is shared by two people, and says, "However, if Sarah and Bob disagree, then Sally shall make the final decision," why not put it in? Then they don't have to go to the PGT.

**Mr Owens:** I guess my question would be in terms of making the settlement binding. How would you go about doing that to ensure that Sally and Bob or Jane and whoever—

**Mrs Sullivan:** It doesn't matter.

**Mr Owens:** How would you ensure that the mediated settlement in fact became the practice?

**Mrs Sullivan:** That's already in the power.

**Mr Winninger:** Could I suggest that the whole purpose of alternative dispute resolution is to try to deal with it outside of the courts, if you will, and if you can't resolve the issue through ADR, then you go the court or tribunal that's appropriate that does have binding power. I think what Mr Sterling is doing is setting out an alternative mechanism sort of coequal with mediation and it's not non-binding and could be contemplated under the existing wording anyway.

**The Chair:** Mr Sterling, could you please re-read the motion in?

**Mr Sterling:** I'm going to withdraw my previous suggestion of legislative counsel and achieve the same thing.

**The Chair:** Mr Sterling moves that section 80 of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by adding the following:

"(2) Subsection (1) does not apply if a power of attorney provides for another mechanism for resolving disputes in the circumstances."

**Mr Winninger:** It sounds like cleaner and better drafting, but it doesn't change our position on the principle. So I suppose, given that there's no harm in it and given that you seem to prefer to have that in there, I don't think we have a problem supporting it.

Motion agreed to.

**The Chair:** Okay, Liberal amendment to subsection 81(2).

**Mrs Sullivan:** Section 81 indicates that an advocate isn't required to meet with a person to explain a matter to

him or her if the person refuses to meet. My amendment would entitle the person to refuse to meet with the advocate.

Interestingly enough, if we go back to our previous discussion with respect to the certification of the power, I indicated that there was an option here for the PGT to proceed if there was a refusal. The argumentation that was given at the time was that the PGT couldn't act, but in fact the bill provides that the advocate doesn't have to meet if the person refuses, so we're automatically into court. But I think we should also acknowledge that the person has the right to refuse to meet.

**The Chair:** Would you like to move your amendment?

**Mrs Sullivan:** Oh, sorry, I thought I did.

**The Chair:** Mrs Sullivan moves that section 81 of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by adding the following subsection:

"Entitlement to refuse

"(2) A person is entitled to refuse to meet with an advocate."

**Mr Winninger:** It may just be stating the obvious, but we don't have any problem with that amendment.

Motion agreed to.

1730

**The Chair:** Government reprint clause 82(1)(a). Agreed? Carried.

Government reprint clause 82(1)(a.1). Agreed? Carried.

Government reprint subsection 82(3). Agreed? Carried.  
PC amendment on section 83.1.

**Mr Sterling:** I withdraw that motion, Mr Chairman.

**Mr Winninger:** Too bad. We liked that one.

**Mr Sterling:** That's why I withdrew it.

**The Chair:** Okay, Liberal motion on subsection 83(2).

Mrs Sullivan moves that section 83 of the Bill, as reprinted to show the amendments proposed by the Attorney General, be amended by adding the following subsection:

"Consultations

"(2) Before making regulations, the Lieutenant Governor in Council shall consult with representatives of persons who may be affected by the regulations."

**Mrs Sullivan:** One of the things that was extremely evident, particularly in the last two weeks of public hearings, was that there's enormous concern about the aspects of these bills which will be invoked through regulations granted under the bills and the necessity of discussion with people who are involved as consumers, as experts in the field, as deliverers, as institutions that will be putting the effect of the law into place. We received no commitment.

This motion and the next motion provide both a time line and a requirement for consultation before the regulations are made and before the act is finally proclaimed and put in place. The purpose of the amendment is to bind the government to discussions and full consultation in the regulatory process with all stakeholders.

**Mr Winninger:** As Ms Sullivan might anticipate, this is completely unacceptable. The language is so broad that it's virtually unprecedented. Everyone knows that there

has to be consultation in order to make implementation of the legislation work, that there's no benefit to government in having regulations that are unworkable, that consultation with representatives of persons who will be affected will take place. I can't understand why this has been floated up, other than as a trial balloon, and I would pop it.

**Mrs Sullivan:** This is being placed before the committee for serious consideration because it came directly from and expresses the views of stakeholders who appeared before the committee with respect to this and the other bills.

These bills, as we know, are companion bills, one affects the others, and whether a person is a health care practitioner, a nursing home operator, a senior citizen who may represent an organization which will be involved in doing educational work or communications work in association with the implementations of these bills or who may want to provide advice to the government with respect to the regulations, this is a resolution that would bind the government to conduct those consultations.

The singular fear that was expressed in the last two weeks of public hearings was that through the course of these bills, there was a sense of rush. The 200 amendments, while improving some aspects of the bill, indeed create other problems and in some cases were unworkable and in other cases were dangerous.

Those issues have been brought quite clearly before the committee, and the people who appeared before the committee were making demands that a new consultative process in terms of the drafting of regulations under this act and under each of the acts be required. In my view, it should be required statutorily.

**Mr Winninger:** I would just respond by saying that the government has, for the past 10 years I believe, been consulting widely with consumers, with professionals, with experts and with providers, and why would it stop now? I think the language of this subsection is extremely broad and unnecessary. I'm confident that the consultation, now that it has been demonstrated and engaged in in the past, will continue in the future to make these regulations work.

**Mr Sterling:** I thought it had stopped two years ago. This is quite a surprise to me.

**Mr Winninger:** That's when we took the reports off the shelf and decided to get on with them.

**The Chair:** Further discussion? Seeing none, we'll proceed to the vote on the Liberal motion on subsection 83(2).

Motion negatived.

**The Chair:** Mrs Sullivan moves that section 84 of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by adding the following subsection:

"Limitation

"(2) Despite subsection (1), this act shall not come into force before the first anniversary of the day on which it receives royal assent."



**Mrs Sullivan:** The reason for this amendment is once again to provide a minimal time line which will be reasonable for consultation with respect to the regulations; but additionally, to develop the implementation plan and bring forward the funding, not only in the planning stages but in the actual implementation stages, make provision for staffing and for full consultation with respect to those issues, whether it's costs, whether it's staffing or whether it's the actual process of operation.

Additionally, even the preparation of forms that are required under this act will require some consultation. I suggest to you that many of these forms will have to be understood not only by capable people and lawyers, but by people who have a lesser capacity. Maybe lawyers should be, but I think that a minimal—

**Mr Sterling:** It's starting to get interesting in this amendment.

**Mrs Sullivan:** The minimum time line, Mr Chairman, is there for a purpose: to ensure that the work is done adequately, to ensure that it is not rushed and to ensure that the funding is in place, that the staff is in place and that the public knows precisely what funding and what staff are in place. We've heard today that in fact no money has been allocated and that the government has no idea of what the impact in either funding or staffing requirements will be as a result of this act.

**Mr Sterling:** I have some problems with postponing the implementation of all of this act for any period of time, because I'd like to see particularly unvalidated powers of attorney for personal care come into play tomorrow. So I'd ask the question: Under section 84, I would assume you have the power to proclaim different sections at different times. I'd like an answer to that question.

1740

The second question I have is, can you foresee proclaiming the sections to permit people to create or to write invalidated powers of attorney for personal care, even though they will not have the right to validate them at that time because that will take some administrative structure to set up?

**Mr Winninger:** As far as your first question is concerned, Mr Sterling, I think you probably well know the answer to that. Sections can be proclaimed effective at different points in time.

As far as the second one is concerned, decisions will have to be made in that regard as to what's feasible and what isn't at what particular time. These decisions will have to be made.

**Mr Sterling:** Could I ask from you, the parliamentary assistant, when we get into committee of the whole House and we're having a discussion on this bill, that you let us know at that time what you're planning has set out in terms of the timing, when people can start to expect to have a form to start?

**Mr Winninger:** I can certainly undertake to convey your concerns to the minister in that regard.

**Mrs Sullivan:** Earlier today the parliamentary assistant indicated that there'd be no funding flow in terms of

planning for the implementation of this bill, and by implication that means that no new staff or staff changes with respect to the implementation of this bill have occurred. In other words, I think we probably have Steve Fram on ministry staff and that's about it.

I don't know if you have anybody else working with you in your department, but it appears that is in fact what the government's action to date has been, that beyond the legislative drafting, there has been no planning and no impact analysis of costs of staff requirements. The parliamentary assistant also indicated earlier that he couldn't give any idea of what the costs in staffing requirements would be.

Mr Sterling has asked for a commitment that this kind of information would be brought to the House when the legislation is put before it. I think this really is a matter of some concern. The action in terms of preparation by the government has been limited. Expectations, however, are high with respect to the new requirements and new opportunities that this bill provides. To suggest that, even before passage of this legislation, implementation efforts and planning efforts aren't funded and staffed is really problematical.

**Mr Winninger:** With respect, Mr Chair, I don't agree with what Mrs Sullivan just said. While some preplanning can be undertaken, the cost consequences, the implementation and specific planning flow out of what the legislation looks like at the end of the day. I don't think it's fair to say that everything can be worked out before we know what final amendments are made in committee of the whole.

I've just been handed a document which I'd like to review for a moment.

**The Chair:** Further?

**Mr Winninger:** Sorry. No, I added what I wanted to add, but I will convey your concerns to the minister.

**Mrs Sullivan:** I think it would also be useful to have an analysis from the public guardian and trustee's office of what the implications are for that operation and how the requirements for the implementation of this bill flowing are seen. I've indicated that at rough count there are about 40 new duties for that office, and in fact there may be more, because we saw another one coming in at the last minute today.

I think this kind of analysis, including staffing requirements, including the training requirements for the staff, including the actual funding requirements, is going to be important. Where is the money going to come from, given the budget that's before the House? I think your estimates have been approved already. They'll have to come forward in supplementary estimates, but we'd like to know that information. We don't think the government has adequately considered those issues.

**Mr Winninger:** I certainly appreciate the concerns you've expressed today and I'll convey them to the minister.

**The Chair:** Further discussion? Seeing no further discussion, we'll proceed to the vote on the Liberal motion on subsection 84(2).

All those in favour? Opposed?

Motion negatived.

**The Chair:** This committee will stand recessed for five minutes so we can sort things out and so that when we go back, we don't miss anything. We stand recessed for five minutes.

The committee recessed at 1746.

1800

**The Chair:** I call this committee back to order. As we're sorting out, we'll go—

**Mr Sterling:** We can deal with one of my amendments, Mr Chairman, under section 75.1. I had asked to stand it down because I was going to propose it. I'm not going to put forward an amendment to that. Therefore, I would be prepared to carry that section.

**The Chair:** Okay. On the PC motion on clause 75.1(1)(e).

**Mr Sterling:** Did I read that one in?

**The Chair:** That has been moved.

**Mr Sterling:** I withdraw that amendment.

**The Chair:** You're withdrawing that?

**Mr Sterling:** Yes.

**The Chair:** Thank you, Mr Sterling.

The first one we have to go back to is the government reprint, subsections 10(1) and (2), as amended. Agreed? Carried.

Liberal amendment on subsection 17(5) moved by Mrs Sullivan.

**Mrs Sullivan:** I think we stood this down. This was with respect to the posting of security by a person who is the spouse, partner, child etc. We had some discussion and I believe the government was going to consider its approach to this. I think that's why it was stood down.

**Mr Winninger:** We have a suggestion that hasn't been reduced to writing by legislative counsel. Let me just convey that to you and you can tell me what you think of it. "The public guardian and trustee may dispense with the requirement for security if the value of the property is less than \$50,000." The use of the word "may" leaves some discretion, where appropriate, to demand security.

**Mr Sterling:** I agree with that.

**Mrs Sullivan:** I think that's fine.

**The Chair:** If you agree with that, would you withdraw your motion, Mrs Sullivan?

**Mrs Sullivan:** Should I withdraw it before I redraft it? I'm not going to take any chances here.

**Mr Winninger:** Speak to counsel beside you.

**The Chair:** We'll stand this down until we get it redrafted.

**Mrs Sullivan:** Thank you.

**The Chair:** Okay, PC motion 17(7.01). This is a replacement.

**Mr Winninger:** We've got a written text now for this amended motion, and we're in accord with it. Is the opposition still in accord with it?

**The Chair:** Mr Sterling moves that section 17 of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by adding the following:

"(7.01) Where the attorney under an incapable person's continuing power of attorney applies under subsection (1), the public guardian and trustee shall give or refuse a certificate appointing the applicant as the incapable person's statutory guardian of property within 30 days after receiving the application, unless the public guardian and trustee has reasonable grounds to believe that the grantor was not capable when the power of attorney was made."

**Mr Sterling:** I think what it does is it guarantees that the public guardian and trustee will react to what should be a fairly routine matter within a reasonable period of time so that people can get on with dealing with the affairs of the attorneyship if any need to do so.

**Mr Winninger:** We're in support of this amendment and I would suggest it carry.

Motion agreed to.

**The Chair:** Would Mr Sterling care to withdraw his motion on subsection 17(7.2)?

**Mr Sterling:** If you'd tell me what that motion was.

**The Chair:** This is the same thing.

**Mr Sterling:** I would like to withdraw that.

**The Chair:** Okay, go back to the government reprint: 17(7) and 17(7.1), as amended. Agreed? Carried.

PC motion on subsection 34(2).

**Mr Sterling:** I think my motion was to delete that section, and I thought we had already done so.

**The Chair:** No, that was stood down.

**Mr Winninger:** If I can confer for a moment.

Interjections.

**Mr Winninger:** "Death," did I hear? Yes, both death and termination of guardianship fall into this. We're prepared to accept, to use Mr Sterling's word "reluctantly," the PC motion.

Motion agreed to.

**The Chair:** PC motion on 39.1(1).

**Mr Sterling:** I withdraw that motion, Mr Chairman.

1810

**The Chair:** Okay, on the government reprint, 39.1. Agreed? Carried.

We have a government motion on 48(1).

Mr Winninger moves that subsection 48(1) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by striking out "subsections (3) and" in the fourth line and substituting "subsection."

Further discussion? Proceed to the vote. All those in favour?

Motion agreed to.

**The Chair:** Government reprint 48(1), as amended. Agreed? Carried.

**Mr Winninger:** He wants to go back to it.

**The Chair:** Do you want to go back to it right away?

**Mr Wessinger:** Yes.

**Mr Winninger:** I'll move it.

**Mr Wessinger:** No, it's Liberal.

**Mr Winninger:** Liberal? You move it.



**The Chair:** Mrs Sullivan moves that section 17 of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by adding the following subsection:

“(5.1) The public guardian and trustee may dispense with the requirement for security if the value of the property is less than \$50,000.”

**Mrs Sullivan:** I think we’ve had the discussion on that.

Motion agreed to.

**The Chair:** Would you like to withdraw your old motion on 17(5), Mrs Sullivan?

**Mrs Sullivan:** I will now withdraw my old motion on 17(5).

**The Chair:** Okay, the government reprint on 17(5). Carried, as amended? Agreed? Carried.

Interjections.

**The Chair:** Now we’ll go to the Liberal amendment on clause 56(2)(a). It’s a new one.

**Mrs Sullivan:** I will be putting forward two motions, and in doing so will withdraw the amendment which I had placed earlier to clause 56(2)(f).

**The Chair:** Mrs Sullivan moves that clause 56(2)(a) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by adding at the end, “and to provide for his or her shelter and safety.”

**Mr Winner:** We’ve had some discussion of this already. We just stood it down to redraft. I think this subsection is acceptable.

Motion agreed to.

**The Chair:** Mrs Sullivan moves that clauses 56(2)(e) and (f) of the bill, as reprinted to show the amendments of the Attorney General, be struck out and the following substituted:

“(e) make decisions about the person’s health care, nutrition and hygiene and give or refuse consent on the

person’s behalf to treatment to which the Consent to Treatment Act, 1992, applies;

“(f) make decisions about the person’s employment, education, training, clothing and recreation and about any social services provided to the person; and”

**Mr Winner:** Again, the matter was stood down for redrafting and we’re satisfied with the redrafting.

Motion agreed to.

**The Chair:** Government amendment on subsection 66(1).

Mr Winner moves that subsection 66(1) of the bill, as reprinted to show the amendments proposed by the Attorney General, be amended by striking out “to 65” in the first line and substituting “and 64.”

**Mr Winner:** It’s a housekeeping amendment.

Motion agreed to.

**The Chair:** Liberal amendment on clause 68(1)(c).

Mrs Sullivan moves that paragraph (1) of clause 68(1)(c) of the bill, as reprinted to show the amendments proposed by the Attorney General, be struck out and the following substituted:

“1. The public guardian and trustee’s certificate that he or she has examined and approved the plan of management, has considered the appropriateness of the proposed guardian and any arrangements for security and does not object to the appointment.”

**Mr Winner:** That’s acceptable.

Motion agreed to.

**The Chair:** Anything further? Mr Wessinger, would you like to make a comment on Bill 109?

**Mr Wessinger:** Yes. I would suggest that we commence on Bill 109 at 10 o’clock on the morning of Monday, September 14.

**The Chair:** If there are no objections, this committee stands adjourned until Monday, September 14, at 10 am in room 151.

The committee adjourned at 1821.











## CONTENTS

Thursday 3 September 1992

Substitute Decisions Act, 1992 . . . . . J-381

### STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

- \***Chair / Président:** Cooper, Mike (Kitchener-Wilmot ND)
- \***Vice-Chair / Vice-Président:** Morrow, Mark (Wentworth East/-Est ND)
  - Akande, Zanana L. (St Andrew-St Patrick ND)
- \*Carter, Jenny (Peterborough ND)
  - Chiarelli, Robert (Ottawa West/-Ouest L)
  - Curling, Alvin (Scarborough North/-Nord L)
  - Harnick, Charles (Willowdale PC)
  - Mahoney, Steven W. (Mississauga West/-Ouest L)
- \*Malkowski, Gary (York East/-Est ND)
  - Runciman, Robert W. (Leeds-Grenville PC)
- \*Wessinger, Paul (Simcoe Centre ND)
- \*Winner, David (London South/-Sud ND)

#### **Substitutions / Membres remplaçants:**

- \*Brown, Michael A. (Algoma-Manitoulin L) for Mr Mahoney
- \*Cleary, John C. (Cornwall L) for Mr Curling
- \*Mammoliti, George (Yorkview ND) for Ms Carter
- \*Owens, Stephen (Scarborough Centre ND) for Ms Akande
- \*Sterling, Norman W. (Carleton PC) for Mr Harnick
- \*Sullivan, Barbara (Halton Centre L) for Mr Chiarelli
- \*Wilson, Jim (Simcoe West/-Ouest PC) for Mr Runciman

\*In attendance / présents

#### **Also taking part / Autres participants et participantes:**

Fram, Steve, counsel, policy development division, Ministry of the Attorney General  
Winner, David, parliamentary assistant to the Attorney General

**Clerk / Greffière:** Freedman, Lisa

#### **Staff / Personnel:**

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Hopkins, Laura, legislative counsel

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J-20

J-20

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## Legislative Assembly of Ontario

Second session, 35th Parliament

## Official Report of Debates (Hansard)

Monday 14 September 1992

### Standing committee on administration of justice

Consent to Treatment Act, 1992

## Assemblée législative de l'Ontario

Deuxième session, 35<sup>e</sup> législature

## Journal des débats (Hansard)

Lundi 14 septembre 1992

### Comité permanent de l'administration de la justice

Loi de 1992 sur le consentement  
au traitement



Chair: Mike Cooper  
Clerk: Lisa Freedman

Président : Mike Cooper  
Greffière : Lisa Freedman

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### **Table of Contents**

Table of Contents for proceedings reported in this issue appears on the outside back cover, together with a list of committee members and others taking part.

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### **Table des matières**

La table des matières des séances rapportées dans ce numéro se trouve sur la couverture à l'arrière de ce fascicule, ainsi qu'une liste des membres du comité et d'autres personnes ayant participé.

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# LEGISLATIVE ASSEMBLY OF ONTARIO

## STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

Monday 14 September 1992

The committee met at 1103 in room 151.

### CONSENT TO TREATMENT ACT, 1992 LOI DE 1992 SUR LE CONSENTEMENT AU TRAITEMENT

Consideration of Bill 109, An Act respecting Consent to Treatment / Loi concernant le consentement au traitement.

**The Chair (Mr Mike Cooper):** I'd like to call this meeting of the standing committee on administration of justice to order. We will be continuing with clause-by-clause on the advocacy package.

**Mrs Barbara Sullivan (Halton Centre):** Before we move to Bill 109, I want to raise another issue. With respect to Bill 74, as you know, the parliamentary assistant to the Minister of Citizenship basically invoked closure while we were considering Bill 74. While the committee was approximately halfway through consideration of that bill, debate was cut off. Certainly the members of the committee on this side were willing to sit in the evening to approach the bill further. The government members, through the parliamentary assistant, indicated that they no longer wanted any further consideration of that bill. We were told subsequently that some of the government members were tired and that this was one of the reasons for not proceeding.

It was very clear, I think, from our reaction, from the reaction of the Liberal Party and the Conservative Party, that we were very angry with the cutoff of debate. We feel that the bill is an important one, that the implications for Ontario society are going to be extensive and that there are problems with that bill. We wanted those problems aired and we wanted an opportunity to present a point of view that was different.

What we are left with now is a process whereby, with whatever amendments are put forward, there will be a simple vote, yea or nay, and without discussion, in my view every single amendment that's put forward by the opposition will be defeated, no matter what its merit and no matter how much people in the province would benefit by those amendments.

Subsequent to the closure motion by the parliamentary assistant for Citizenship, the parliamentary assistant to the Solicitor General came quietly to me and, I believe, to the third party and asked if we would be willing to sit this evening and tomorrow evening to do additional work on Bill 74. We indicated that we would like to hear a more formal proposal. I really believe that if the government intends to reopen Bill 74, so that we have an opportunity to speak to it, it would be an appropriate thing to do. I would like to know how serious the government is in terms of reopening Bill 74 and sitting on that bill tonight.

**Mr David Winninger (London South):** Perhaps I could speak briefly in response. Notwithstanding the fact that we debated Bill 74 for two full days and notwithstanding the fact that we were prepared to sit late on the Tuesday night in the last week of clause-by-clause to continue debating Bill 74, but we were somewhat stymied on the government's side from doing that, I did indicate to Ms Sullivan that if there was time left over after we debated Bill 109 and Bill 110, we'd be disposed to come back and participate in further debate on Bill 74.

Mr Wessinger of course has carriage of Bill 109 and he may state his wishes, but it would be our proposal that we sit late tonight dealing with Bill 109 and then continue dealing with Bill 109 until we've completed it, hopefully devote an afternoon—for example, tomorrow afternoon—to Bill 110 and then devote time available Wednesday to Bill 74 again. Mr Wessinger may wish to add to what I've just said.

**Mr Jim Wilson (Simcoe West):** Just to briefly comment on this, I think it's imperative that we look again at Bill 74 because we were closed down by Mr Malkowski in a very abrupt and, I think, rude fashion, with no warning to the opposition parties. Effectively, we were told at 6 o'clock on the last day we were debating Bill 74 that there would be no more debate on Bill 74. I think it's been irresponsible of the government.

If you look at the number of amendments that were stood down and agreed there would be further debate on, and if you look at what has been left for the public to have to deal with if the legislation were to pass without further clause-by-clause review, it's a real mismatch and in fact doesn't make sense in some areas because of the amendments, many of them PC and Liberal amendments, that were stood down and need to be included in that legislation. I think, in terms of responsible government, it's imperative that the government of the day, the NDP, revisit this bill and ask its House leader for more time, if that's required.

**Mr Gary Malkowski (York East):** Just for the record, I certainly appreciate the Liberal member raising concerns. One point of clarification: Two weeks ago we agreed that we would follow the schedule of 2 until 6 on debate of the bill. That was a point that was agreed to by all parties. However, we were willing in the first place to try to get through Bill 109 and Bill 110 and agreed that if there was time left, we would certainly reconsider opening discussion on Bill 74, should the schedule permit. That's just a point of clarification.

**Mr Paul Wessinger (Simcoe Centre):** I'd like to add that I would certainly be prepared to cooperate in trying to get Bill 109 through as quickly as possible in order to return to Bill 74. I just want to put that on the record.



1110

**Mrs Sullivan:** I find it very interesting that we hear: "If there's time left over, we can go back to 74. We'd like to get rid of Bill 109 as quickly as possible."

Frankly, these responses are simply inadequate. These are extremely important bills. They're extremely important pieces of legislation. They affect every single health practitioner and every single individual in the province and have particular effect on people who are vulnerable or incapable, and we're talking about this entire process as if it's something to get out of the way: "If there's time left over," and, "Let's deal with this as quickly as possible."

By direction of the House, we've been given seven days to deal with four bills. The process has been one where one of the ministries in particular, the Ministry of Citizenship, has been unwilling to discuss the issues associated with that bill. The other two ministries, Health and the Attorney General, have certainly provided additional time with the opposition, and with consumers and practitioners, with respect to discussion.

We don't know what the process will be and what the time lines will be in terms of dealing with Bill 109. It may be fairly simple, but on the other hand, we have some pretty darned important amendments to put forward that will require discussion and debate. We would like to see that discussion and debate occur at a time when we can be assured there is full time to deal with it.

We had agreed there would be two full days for Bill 109. I would like to ensure that we have two full days, today and tomorrow, for Bill 109. We are prepared to sit tonight on Bill 74 and we are prepared to sit tomorrow night on Bill 74.

Bill 110 is also a complicated piece of legislation that ties all these other pieces together. We understand there are a number of government amendments coming forward, most of them out of order, I might add, and we have not seen them. They will affect all the other bills.

What we have now from the government is "if time is left over" and, "Let's deal with this one as quickly as possible." We will have two days in committee of the whole in the Legislature for these bills. I think this is absolutely, frighteningly inadequate.

**The Chair:** Any further discussion?

**Mr Jim Wilson:** I too am very concerned about the phrase "if time is left over." I think it's an irresponsible approach to formulating legislation. We gave our commitment from the beginning, as a PC caucus and as members of this committee, that we would be as cooperative as could in trying to put together legislation that we feel the public can live with, even though we feel much of this legislation is unnecessary, wasteful and a wasteful expenditure of taxpayers' money.

"If time is left over" is irresponsible. I'd like to see a further firm commitment from the government that we will be allowed our full two days on Bill 109, our full day on Bill 110, and that we will go to the House leaders—their House leader, Dave Cooke—if need be, and ask for a further one or two days that may be required to deal with Bill 74. The government has created the animosity on this

committee surrounding Bill 74 and I think it's imperative that it show goodwill and give us some level of comfort that the bill will not be just sloughed off.

Otherwise, we are going to give you one of the hardest rides you've ever seen in committee of the whole House in the Legislature. If you want to do that in front of the whole province on TV, fine, we're quite willing to do that, but I think it would be in your best interest and in the public's interest if we were assured that full time would be given to us to fully discuss Bill 74, the number of amendments that were already stood down and the number of amendments yet to be introduced.

**Mr Winninger:** I certainly don't appreciate Mr Wilson's threats. On the one hand, he's saying he's trying to be as cooperative as possible, and at the same time he's threatening behaviour in committee of the whole.

**Mr Jim Wilson:** That's what I'm promising.

**Mr Winninger:** I can simply restate our position. Two days were allotted to Bill 108. Two days were given for debate. If there's time left over—I shouldn't say it's entirely up to the opposition, but we can make the time work for us if we want to be constructive about this. If you insist on two full days for Bill 109 and we sit tonight, then there's no reason why we couldn't finish Bill 109 at noon tomorrow and move on with Bill 110. Then we'd have time available on Wednesday.

We're certainly not going to approach the House leaders again and ask them to reopen this. Your House leaders participated in the allocation of time for debate of these bills. I think we've bent over backwards to sit late to get through these bills, and I don't think it's appropriate now, at this late date, to come forward and say, "Go back to your House leaders and ask for more time."

We can make this work; we can find time for Bill 74. But if you insist on your full day for Bill 110, a housekeeping bill essentially, and two full days on Bill 109, then it's clear we won't have time for Bill 74.

**Mr Wessinger:** I'd just like to make it clear that with respect to Bill 109, certainly we're prepared to sit this evening to whatever hour the opposition would like to continue to proceed with that bill. Also, as I said, I have no objection to evening sittings at all with respect to this matter. I just thought I'd put that on record. In fact I've advised members of the committee that I expect that we would be sitting this evening.

**Mr Malkowski:** Again, just for the record, it is important to understand that the House leaders did make an agreement on time allocations and that we did limit time to two days per bill. What we have been willing to do is in fact do a bit more than what we agreed. With advocacy, we sat Monday, Tuesday, and we included evening sittings and added the extra time Wednesday afternoon, so in fact we sat more than two days on the Advocacy Act.

The point is that we have been more than willing to make concessions. We are again happy to say, if we can get through Bill 109 and have extra time—it's important that the opposition members realize that the schedule is something that all three leaders agreed on. It's not something



that we had control over. The allocation times were a three-party agreement, and we have held that.

**Mrs Sullivan:** I want to correct the impression that there was warm and hearty enthusiasm from the opposition parties with respect to this time allocation. In fact, there was not that warm and hearty enthusiasm. We wanted public hearings again after the government brought in 200 amendments to the package of four bills.

In order to get those public hearings, to enable groups and organizations and individuals who had a professional and consumer interest in these bills to have a say with respect to those amendments and to how those bills would work if they were implemented in the form that those amendments were brought forward, we had to agree—there was an insistence that we agree—on a compromise that included time allocation.

This is the exact same approach the government took when it brought in the Labour Relations Act and, that very afternoon, changed the rules of the House. In this case, to ensure that we had concurrence that people from the public would be able to comment on these bills, we had to concur with time allocation. It is absolutely outrageous to give any hint that there was enthusiastic agreement for time allocation. This is inadequate time. Anybody in his or her right mind knows that it's inadequate time.

**Mr Norman W. Sterling (Carleton):** I'm disappointed in the process sort of breaking down at this time. Up to this time, I think that both opposition parties have acted in a responsible manner in trying to bring forward reasonable debate. I don't think that on any particular point the debate has been approaching any kind of filibuster or trying to lengthen it beyond the time when people were legitimately putting forward their arguments with regard to amendments.

We're dealing with some very important and complex legislation. It has been our continued desire to try to resolve the difficulties to come out with the best piece of legislation possible in the end. But ultimately we in the opposition realize that it is the responsibility of the government to have it right. Now if the government insists upon pushing this process faster than it should go, it bears the ultimate responsibility for the mistakes made in constructing this legislation.

1120

We can argue on both sides to try to make political marks that we are willing to sit here till 10:30 tonight or 9:30 or after dinner or whatever. But there comes a time in every day when the debate becomes fruitless and the progress stops, and usually that happens after we have expended enough energy during the day that we no longer can carry the conversation to a successful conclusion in this forum.

If the government doesn't want to remain flexible with regard to how we carry on and the procedure on this, that'll be tough; it will be tough for us, and it will be tough for the many interest groups which I think have done an excellent job in spending valuable resources and time in putting forward their positions. But I don't think saying we

are going to sit here till 12 o'clock tonight and 12 o'clock tomorrow night is going to indicate or produce progress.

I suggest we start off, we carry on as best we can and if the government cuts us off, it's going to be on its neck that hangs an imperfect piece of legislation. In the case of Bill 74 and Bill 109, I think both of those pieces of legislation are badly flawed. But if they don't want any more debate on it, they don't want to hear anything more about it and they don't want to act constructively in this process, I guess they're going to cut us off. It's the public of Ontario, the health care system in particular, that's going to suffer as a result of it.

**The Chair:** Quite possibly at lunchtime or at dinner-time the subcommittee could get together to determine what kind of hours it would like to sit rather than debating this till whenever this morning. Right now we'll proceed with clause-by-clause on Bill 109, the Consent to Treatment Act. Opening statements?

**Mr Wessenger:** Before we proceed with the clause-by-clause review of the Consent to Treatment Act, I'd like to make a few comments to the members of the committee on behalf of the Minister of Health. First, I'd like to thank those who have worked so hard and diligently for so long on this legislation, and that's our legal counsel Gilbert Sharpe and also Jutta Auksi and Guiseppa Bentavegna, who have given hours and hours of time trying to make this legislation the best possible.

Second, I'd like to thank the committee members from all parties for their cooperation and support in shaping this legislation. I'd also like to thank the many organizations and individuals who appeared before this committee or who sent in presentations. This public process was an important opportunity for interested parties to come forward with their views and ideas on how the legislation might be improved.

I think it's apparent to all of us that Ontario needs legislation that specifically addresses the issue of consent to health treatment, wherever health care is provided, and that we need legislation that applies uniformly and equitably to everyone. In recent years, the need for clear statutory rules on consent to health care has been expressed by health care consumers, providers, experts in the health care field and interest groups.

The issue was raised not only by the Fram report of 1988 but during the amendment process for the Mental Health Act, the discussions on the Public Hospitals Act, which are still under way, and the public meetings on proposed community mental health legislation.

Furthermore, in the June 1991 Ontario Court of Appeal decision in the case of Reid and Gallagher, Mr Justice Robins summarized the principle of informed consent when he wrote the following:

"The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination. The doctrine of informed consent ensures the freedom of individuals to make choices about their medical care. It is the patient, not the doctor, who ultimately must decide if treatment—any treatment—is to be administered."



In Ontario at the present time, no legislation exists that deals comprehensively with the issue of consent to health services. The Consent to Treatment Act, 1992, attempts to codify all the elements in consent to health services in one piece of legislation.

As members will recall, in her remarks to this committee last December, our Minister of Health, Frances Lankin, said she was more than willing to work with this committee and other groups to refine and strengthen the Consent to Treatment Act.

The government and this committee listened closely to the presentations that came before us, and we amended the legislation to accommodate many of the concerns and issues expressed. I believe we now have a bill that meets the needs of health care consumers, health care providers, indeed all those with a stake in the effective operation of our health care system.

Let me highlight just a few of the more important issues that came before the committee and how we dealt with them.

This committee heard concerns that a mandatory advocate visit in each case where a person was determined mentally incapable would cause unjustifiable delays in treatment for incapable persons, and there was confusion about the role of advocates under this bill.

In response, we amended the legislation so that the term "advocate" has been replaced with the term "rights adviser" to clarify that the role of the rights adviser in this legislation is a narrower rights information role and not the broader social advocacy role set out in Bill 74, the Advocacy Act.

We've also limited rights advice to persons who are 12 years of age or older.

In psychiatric facilities, a person who is determined mentally incapable with respect to treatment will be given a notice of rights and a meeting with a rights adviser is mandatory. This continues what is currently in place in psychiatric facilities.

In other settings, a notice of rights will be required only if the treatment is a controlled act as defined under the Regulated Health Professions Act. A meeting with a rights adviser will only take place if the mentally incapable person asks to meet with a rights adviser or objects to the treatment.

We heard concerns expressed about setting a presumption of mental capacity to treatment at age 16. Numerous groups presenting at the hearings expressed the fear that the reference to age 16 would result in adolescents being refused or failing to seek needed health services. The majority of these groups requested that no presumption of mental capacity based on age be set out in the bill. Their preference was to leave the determination of mental capacity to health practitioners who would apply the mental capacity test set out in this legislation.

In response, we amended this legislation so that there is now no reference to age in regard to mental capacity, and I can't emphasize this point strongly enough, because we still see media reports giving misinformation about presumptions of mental capacity and incapacity with a reference age of 16.

We also heard concerns about the original legislation that a mentally incapable or unconscious person could be at risk in not receiving prompt treatment in an emergency. Health practitioners felt that clarification of the original emergency provisions were needed to permit them to conduct an examination of an incapable person to determine if an emergency existed.

In response, we broadened the criteria for administering treatment to a mentally incapable or unconscious person. The current provisions of this bill state that emergency treatment is permitted if the incapable or unconscious person is experiencing severe suffering or is at risk of suffering serious bodily harm if treatment is not administered promptly.

A provision has also been added clarifying that a health practitioner is permitted to examine an incapable person to determine if an emergency exists.

Finally, if a substitute decision-maker, other than a court-appointed guardian, an attorney for personal care or a board-appointed patient representative, is refusing emergency treatment and the health practitioner has reasonable grounds to believe that the substitute decision-maker is not complying with the incapable person's prior wishes and is not acting in the best interests of the incapable person, emergency treatment can be given.

That concludes my comments on the Consent to Treatment Act. As we move into the clause-by-clause review of this bill, I hope the goodwill and cooperation that has characterized our discussions to date will continue. We're all interested in making this the best possible legislation, and I look forward to hearing the comments and suggestions of the committee members during this part of the committee process.

**The Chair:** Mrs Sullivan, opening statement?

**Mrs Sullivan:** As you know, my party has for some time agreed with the principle of the codification of the law with respect to consent to treatment to ensure uniformity and equity in application of the principles of informed consent across the province.

I think we have all signed a form to consent to medical treatment at one time or another with respect to either ourselves or our children or parents perhaps in certain situations.

One of the things we know is that there is a great deal more than simply signing a form, that the provision of consent and the form itself is merely evidence of the consent; it's not the entire process of consent.

1130

We had hoped that through this process, the codification of the consent to treatment provisions would involve a cautious, careful and appropriate discussion. We have found that because of a certain sloppiness on the part of the government—in fact, a substantial sloppiness on the part of the government, in my view—the process with respect to Bill 109 has become confused and controversial.

We know that because the bill is presented as part of a package, the Consent to Treatment Act does not stand alone; the interrelationship with Bill 108 on substitute decision-making, with Bill 74 on the Advocacy Act and of course



with Bill 110 created substantial controversy and substantial confusion.

The bill became not merely a codification of common law. In fact the inclusion of an extra layer of advocates in the first go-around brought a new dimension of ideology into the proposal of codification of the law. It became very clear that there was suspicion on the part of the government of the care giver and there was suspicion on the part of the government of the institution, and that suspicion was thinly veiled.

One of the problems here was that there was no specific consultation before the introduction of this legislation. I think that's a shame. I think it's also really one of the greatest negatives in association with this presentation.

The last government, as you know, had circulated a paper for discussion with relationship to the principles of consent legislation. An election intervened and the process of consultation with respect to the principles of consent was never completed. This government, when it came to power, simply moved ahead and none of the health care professionals or consumer groups had input into the formulation of the bill, nor indeed into the discussion of the principles that should have been behind the bill.

The minister apparently didn't seem to be interested. But for one session in committee, she has not attended the public hearings and has apparently not been attentive to the critical issues that were being aired. While changes were made, and many of them were welcome changes, they were only made when it became clear that doctors, by example, couldn't even make an appropriate diagnosis or deal with any sort of emergency as the bill was first written.

There's no question in my mind that ministry officials understood that the legislation couldn't proceed in that form. The opposition certainly understood that the legislation couldn't proceed in that form. Health care providers and every single health care organization that appeared before the committee understood that the legislation couldn't proceed in that form. In order to provide medical services, the law would have to be broken. It was as simple as that.

Even with the changes that have been made to the bill, the bill still isn't right. I will be presenting a number of amendments that I hope will correct some of its greater deficiencies. I've discussed those amendments with officials in the ministry, with health care providers and with the minister herself. I am hopeful that the government will accept them and that we'll end up with a law that's principled and that's practical.

There are two things that I want to raise additionally as points of regret. We asked in committee for a statement with respect to the age issue, and common law with respect to age. We received that late, but it was a well-prepared document and I think we're all grateful for it. In the course of reading that document, however, it became apparent to me that the Weisstub report is available in draft form. Indeed, in the document there are quotes from the draft Weisstub report.

I've indicated on a number of occasions that I'm concerned that the research provisions of this bill in fact do

not adequately explore the issues associated with the ethical treatment and equitable treatment of research, given that there is a surround of discussion that should be taking place here.

At the beginning of the committee we understood, and we were told in fact in committee, that the Weisstub report would be available for us to include in our consideration. I'm disturbed that it's not, and I believe that in fact there is a gap in this bill and that we'll have to, within relatively short notice, as soon as the final report is finally made public, return to that.

I will be making amendments, as I've indicated, that will separate the rights advisers from the Advocacy Commission and bring them under the full purview of this act separately. I will be moving mandatory rights advice and putting the patient in the position of being able to request rights advice and having information and official notification about the right to appeal.

I will be presenting amendments with respect to the diagnostic procedures so that a physician in making a diagnosis will not have to receive consent for the diagnosis. I will be making recommendations based on those that have been put forward to us suggesting that the health practitioner can act on reasonable grounds and in good faith, without negligence, and I will be making recommendations with respect to providing rights notice to those people who are 16 years and older.

There is no question that this is important legislation. We feel very strongly that it has to be right, that it has to be able to work not only for the patient but for the health practitioner and for the institutions which will be responsible for using it.

We also are very concerned about the implementation of the bill. Our concerns were aptly summed up by the ad hoc committee which has indicated that it wants ongoing and further consultation as the regulations are devised and as the processes are put together. Without that kind of consultation, this bill will definitely not work.

**Mr Jim Wilson:** I want to begin by once again expressing my displeasure and concern that the Minister of Health has not once had the courtesy or the respect for members of this committee or for this committee as a whole to appear before the committee to help out the process. The process would be greatly enhanced if the minister were to at least show the courtesy of appearing here.

As Mr Wessinger indicated in his opening remarks, what has happened is that the government feels there is misinformation and misinformed media reports out there. Why hasn't the Minister of Health made any attempt whatsoever to appear before this committee during clause-by-clause to try to clear up some of that confusion? It's in her and the government's best interests to bring the full weight of her office to this process. The position she holds is not that of parliamentary assistant; it is that of minister.

What we're very much concerned about in particular with Bill 109 is that, in spite of our efforts to work with the government, we still believe there is an underlying suspicion in this legislation that this government does not trust health care practitioners or care givers; it's riddled throughout the legislation. There's indeed a mistrust of the



people who are in fact entrusted by the public and are licensed under the Regulated Health Professions Act to administer treatment to people in need of medical treatment in our society.

The government, in all of its dealings with the medical profession in particular, has sent out a dangerous message to the public, indicating that it doesn't trust doctors to do their jobs. That's abhorrent and we're going to work the best we can to gut provisions in this legislation that send out those messages to the public.

We think Bill 109 loses sight of the primary responsibility of health care providers and care givers, and that's the right of the patients to quality, effective and timely treatment for their ailments. What we see in Bill 109 is really a primacy of the right to informed consent over that of the right to treatment. We will be working very hard to try to bring back a balance to this legislation and in fact to try to get as much of the status quo as possible into this legislation because we trust health care professionals. I know the Liberal members agree with us in that approach.

To emphasize the fact that the legislation places the act of informed consent in principle above all else, I want to quote from a press release of last Friday that was issued by the College of Physicians and Surgeons of Ontario. I can think of no higher body, no higher authority than the CPSO because it is its members, it is the physicians in their offices, in the mental health facilities and in the hospitals who have to make this legislation work when we wash our hands of it. Once this legislation is enacted, it's up to the medical community primarily to make it work.

I want to quote where it starts, where the CPSO, the College of Physicians and Surgeons of Ontario, warns that:

"The bureaucratic complexities of the consent to treatment legislation will force health care workers to observe technical compliance above all else. If the government wants to ensure that the interests of vulnerable or incapable people do not get lost in legalisms, then it must allow health care practitioners, whether nurses, midwives or doctors, to act in accordance with the judgement they are trained to deliver."

1140

I don't think any member of this committee could have summed it up better than the underlying principle in this legislation, although it's masked in wonderful social democratic language and language of empowerment—what I see in this legislation—is a fundamental mistrust of our health care practitioners and health care providers.

We want to ensure, Mr Chairman, that the status quo is maintained in the treatment of persons under the age of 16. We do not think formalizing the consent process for persons under the age of 16, as this legislation attempts to do, does anything to help improve the provision of health care for these individuals, so we'll be introducing amendments along that line.

We want to ensure that the legislation makes it easier for families to obtain the necessary treatment for their mentally ill relatives. We've had a tremendous amount of compelling testimony during the public hearings on this legislation that families have been left out. We saw that in Bill 74 in the advocacy legislation and in Bill 108, and it is

evident also in Bill 109. We haven't been able to rout it out to the extent that I think is necessary.

Again the emphasis seems to be on the rights of the mentally ill person rather than the primary concern, which should be the right to effective and quality treatment. We want to ensure that the role of the rights advisers is clarified in this legislation. There is confusion out there as to what the role of the rights advisers will be. In fact I'll go so far as to say we want to limit the role of rights advisers. We want to ensure that rights advisers are not an unnecessary bureaucratic mess for health practitioners to deal with.

People expect—I know my constituents expect—when they walk through the doors of the emergency room in their hospital that they go there for treatment, not rights advice. We want to work very hard to ensure that the emergency provisions in this legislation are again amended to reflect a commonsense approach to providing effective medical treatment in cases of emergency.

I think this legislation must not be allowed to circumvent any of the safeguards that are currently present in dealing with children and youths, those safeguards that now exist in the Child and Family Services Act. We'll be ensuring that this is the case and we'll be looking for the cooperation of the government in those areas.

Mr Chairman, just to sum up, I want to make it absolutely clear that we trust our health care practitioners. If the government doesn't do that, then the minister should appear here herself and tell us why it doesn't trust health care practitioners. If you want to clear the air, the minister should be here. We've not seen her at all during clause-by-clause hearings, and she'll be left to defend this, having not participated in the hearings, during the committee of the whole debate in the House. I think that will indeed be an interesting time.

I know Ms Lankin will be well briefed, but will she be fully aware of the tremendous concerns that have been expressed to this committee? These concerns, once again, as late as last Friday were expressed by the College of Physicians and Surgeons of Ontario, the leading authority in dealing with Bill 109. We should listen to the CPSO and to those other health care practitioners and groups that have expressed concerns and the need for even more amendments to this legislation. We will be doing our best to introduce those amendments on behalf of those groups, to work with our other opposition colleagues and to try to solicit the support of the government members.

Mr Wessinger ended his remarks by talking about the cooperation and goodwill that has existed to date. I suggest somebody in the Ministry of Health wrote those remarks without appearing before this committee, again reflecting that if that's the opinion of the minister, then I would say she's missed the gist of what's going on around here. We had goodwill and cooperation until we were shut down on Bill 74 and we had goodwill and cooperation until a number of amendments that we felt were badly needed had not been passed. Indeed, in some cases they've been set aside and we've been told that we may not have time to go back and revisit those.

I would ask the government members to convey to their respective ministers that all is not rosy on this



committee, that if they have that impression they're misinformed. If the media give the impression that all is not well at this committee to the public, then I would have to agree with it. I would not, like Mr Wessenger, try to cover it up by saying the media is misinformed. I don't think that's the case at all. I think the ministers are misinformed.

**The Chair:** Thank you, Mr Wilson. For the committee's information a letter has been distributed regarding the recommendations of the official guardian concerning guardianship and advocacy legislation and age of consent. You have it at your places.

We'll now start in to clause-by-clause consideration. The first one is on the government reprint. We have a deletion in subsection 1(1). Discussion, comments? Seeing none, all those in favour? Agreed.

We have a PC motion next.

Mr Jim Wilson moves that subsection 1(1) of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following definitions:

"'plan of care' includes a plan that outlines an individual's day to day personal care, social, spiritual and recreational activities and that has been consented to by the individual or by a person authorized to consent on the individual's behalf;

"'plan of treatment' includes a plan that involves the administration by a health practitioner of a prescribed procedure that is invasive or that does not occur on a regular basis."

**Mr Jim Wilson:** I think the definitions are self-explanatory. We're simply trying to clarify this area of the act. We had a number of witnesses appear suggesting, and I think they're very commonsense and good suggestions, that a plan of care be included so that, for instance, patients or clients in nursing homes will not have to be disturbed through the invocation of the rights advisory process each and every time one of their day-to-day health care treatment activities is carried out. It makes sense to accept these amendments, and I would look for all members' support on this.

**Mr Wessenger:** We'll be opposing this amendment. The plan of treatment is already included in the definition of treatment and the definitions, if they were added into this legislation, I think would create a great deal of confusion at this stage and would cause many other drafting requirements. It would not be beneficial, and I don't think it's necessary to define every word in the bill.

**Mr Sterling:** Am I hearing the parliamentary assistant correctly, that because we have to amend other parts of the bill, that's his major objection to this?

**Mr Wessenger:** There are some other objections and the whole question of plan of care items are—

**Mr Sterling:** I think it's more important than the hard task of amending the other parts of the bill. What are your objections?

**Mr Wessenger:** We don't feel that it adds anything to the bill; it detracts from the overall legislation. Under plan of care we have items included that really have nothing to do with health care, such as social, spiritual and recreational activities. They have absolutely nothing to do with health care. They may relate to the health of the individual but they certainly do not relate to consent to treatment.

**Mr Jim Wilson:** The Ministry of Health must be using a different definition of health care than the one I've become familiar with. It would seem to me the day-to-day personal care, social, spiritual and recreational activities that are carried out in a facility are very often part of the plan of care of an individual patient.

I suggest to Mr Wessenger that there will be a lot of groups and a lot of citizens of Ontario who would disagree with his definition of health care. The fact that more work may have to be done to wording in other parts of the legislation to conform to these definitions is a pretty lame excuse and in fact we've done a lot of that work for you, Mr Wessenger. We've introduced amendments to help the act conform to these new definitions.

**Mr Wessenger:** I'd just like to add that we're dealing with treatment under this act, not the question of health care.

**Mr Sterling:** The whole purpose of this amendment is to try to get out of the treatment section, particularly for long-term health care areas, those things we would not deem as invasive or so much associated with something that would be normally deemed as questionable even in the public's mind; for instance, cleanliness and personal care of the individual. I guess we're trying to make certain that those parts of what some people might deem health care in fact aren't part of treatment under this act. I think that's really where we're driving with this particular amendment.

**The Chair:** Further discussion? Seeing no further discussion, all those in favour of the PC motion on subsection 1(1)? Opposed?

Motion negatived.

**The Chair:** In the government reprint, clauses 1(1)(a) to (a.13). Discussion? Carried? Agreed.

Since it is close to 12 noon and we're going on to rights adviser—I imagine it's going to be a fairly lengthy discussion as there are five amendments to it—possibly we could recess now until 2 o'clock this afternoon. This committee stands recessed.

The committee recessed at 1153.



## AFTERNOON SITTING

The committee resumed at 1421.

**The Chair:** I'd like to call this meeting back to order.

**Mr Winninger:** I was going to ask whether we could have unanimous consent to a late substitution of Ms Akande at 4 pm by Mr Sutherland, whether the opposition parties would consent to that substitution.

**The Chair:** Do we have unanimous consent?

**Mrs Sullivan:** We understand that the government wants a full contingent of its members here. What we're concerned about is that once again there's evidence of the clear sloppiness in its approach to this committee work. They hadn't made any arrangements for substitution as is appropriate, and a well-managed caucus would have done so. It just seems to me that once again it is sheer negligence of duty.

We have asked that the government also accept its responsibility by returning to Bill 74 this evening. We've indicated that we are prepared to sit tomorrow evening. We have intransigence once again from the government, which believes that Bill 109 can be swept aside, dealt with quickly. We heard this morning that this is its attitude.

As far as I'm concerned, we will accept that Mrs Akande can have another substitution. We think the government should pay more attention to its responsibilities, not only in the legislative area but in the process of parliamentary conduct as well.

**Mr Winninger:** I'm pleased that I hear some consent from Ms Sullivan, but I'm sure she would acknowledge that in her party as well as ours emergencies do come up in scheduling and sometimes it's necessary to substitute.

**The Chair:** Thank you. Once again, do we have unanimous consent? Agreed.

Now, as for broadcasting and Hansard, they have to know, and the dining room will have to know, whether or not we're sitting late this evening. Do we have any agreement on what we're doing this evening?

**Mr Winninger:** It would be the government's position that we would like to sit and debate Bill 109 until 9 pm with an appropriate break for dinner.

**The Chair:** Any discussion?

**Mrs Sullivan:** Our position is quite clear. We've had a day and a half of debate during the daytime on Bill 74 and we sat one evening, not two, as one of the government members indicated. We would like to go back to 74 tonight. We want the full two days for Bill 109, being today and tomorrow. That's our position.

**Mr Winninger:** I feel I have to correct for the record a statement that Ms Sullivan just made that we had a day and a half of debate on Bill 74. That's not the case. If you take the evenings we met and the Wednesday afternoon we met to deal with Bill 74, we have a total of over two days of debate on Bill 74.

**Mrs Sullivan:** And it's not enough.

**Mr Winninger:** I believe I still have the floor. I need not remind Ms Sullivan yet again that that's pursuant to the agreement of all three House leaders.

**The Chair:** Do we have consensus on this evening?

**Mr Jim Wilson:** I would just as soon work right through dinner and have some sandwiches brought in, because the sooner we get this done, the better. There's no use breaking for two hours or something and then having to come back. A lot of us have things to do in the evening, like phoning our constituents back who have phoned us all day.

**Mr Malkowski:** Just a point of clarification: We're talking about whether or not we're agreeing to sit until 9 tonight to discuss Bill 109. Is that correct?

**The Chair:** I haven't received any clear indication of what we're meeting on this evening. It seems everybody wants to meet this evening; it's just not clear what we're meeting on.

**Mrs Sullivan:** I would like to make a motion that the committee sit this evening to consider Bill 74.

**The Chair:** Mrs Sullivan moves that we sit this evening to consider Bill 74.

**Mr Winninger:** We'll be opposing that motion.

**Mrs Sullivan:** Could we have the reason?

**Mr Winninger:** I think it's been made clear over and over again that two days were allocated to the debate of Bill 74. We have other legislation to debate over this and the next two days. It may to some extent be the opposition's prerogative how it chooses to deal with those three days, but the government has indicated a willingness, once debate has been concluded on Bill 108 and Bill 109, to come back and discuss any outstanding issues on Bill 74. That's the position that was communicated in good faith to Ms Sullivan in the last week of clause-by-clause.

**Mr Sterling:** We really don't care which we deal with tonight. It doesn't matter to us. We'd just like to get on with whatever we're doing. Let's go.

**The Chair:** Further comments? Seeing no further comments, all those in favour of Mrs Sullivan's motion? Opposed?

Motion negatived.

**Mr Winninger:** I would move that we adopt the suggestion of Mr Wilson that we have a working dinner. Whether we sit until 8 or 9 tonight requires, I guess, some agreement from the other opposition members.

**Mr Sterling:** Let's just continue on until we feel that we're running up against a wall and that we're not getting anywhere—I think everybody recognizes that in the committee—and then quit when that happens.

**Mr Winninger:** It was understood that the broadcast booth and translators and so on need to have some indication of how late we were sitting today.

**Mr Jim Wilson:** When we know, we'll tell them.

**The Chair:** It seems we do have consensus that we will be working through dinner and into this evening.

**Mr Sterling:** Let's say we won't go past 9 o'clock, for their purposes, and to respect their lives as well in terms of their schedule and that kind of thing.

**The Chair:** Do we have consensus on that? Agreed.

Can we continue where we left off? Liberal motion, Mrs Sullivan.

Mrs Sullivan moves that the definition of "rights adviser" in subsection 1(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"'rights adviser' means,

"a person who is a member of a prescribed category of persons authorized to give rights advice in prescribed circumstances."

**Mrs Sullivan:** This recommendation and this amendment take out what is clause (a) of the current proposal for amending the definition of "rights adviser" and would limit the rights advisers to those people who are authorized under the Consent to Treatment Act as a prescribed category of persons, so that the package in terms of the Consent to Treatment Act is a standalone package. We believe it is the appropriate way to go. Practitioners and consumers who have expressed an interest in this area support this amendment and we believe the government should support it as well.

1430

**Mr Wessenger:** We'll be opposing this amendment. I think, first of all, the present definition does provide the option for having a standalone because a "rights adviser" is defined as either "a person who is authorized under the Advocacy Act" or "in the prescribed circumstances, a person who is a member of a prescribed category." So it provides the flexibility of either doing it all under the Advocacy Act, doing it under the Advocacy Act and having other persons deliver or having an evolutionary model. It gives it a great deal of flexibility.

I think there are some concerns about establishing rights advisers to have a body to which rights advisers are responsible, and certainly the Advocacy Commission provides that body for training and responsibility of rights advisers. For that reason, we'll be opposing the amendment.

**Mr Sterling:** I don't quite understand why one group of rights advisers, ie, those advocates under the Advocacy Act, would be given supremacy over other rights advisers. There are four amendments in regard to this particular section. One of ours just says that it will be anybody who is prescribed in the regulations, and therefore if it was the wish of the government of the day to include advocates under the Advocacy Act, they'd be included; if it was the wish of the government of the day that other people would be included, they would be included.

I don't understand why there's a special category (a) under this act. Why wouldn't you just say a rights adviser is anybody who's prescribed? Can you tell us who you have in mind as rights advisers?

**Mr Wessenger:** Yes. I think we might have the policy person, Jutta Auksi, answer that question.

**Ms Jutta Auksi:** I think there are a couple of issues here. One of the things of course is that in the Advocacy Act there is a requirement that they are to do this if they are mandated by the Ministry of Health to do it. Without that provision, just putting it in the regulations, there might be some question as to whether the Advocacy Commission would have to agree to do it.

From a practical point of view, I can say, from having been very closely involved with the establishment of the existing rights advice program that operates in the psychiatric facilities, that it's extremely important for rights advisers to have a coordinating body.

The part of the program that presently operates in the provincial psychiatric facilities is much more effective in a lot of ways, I would think, than the part that operates with duty counsel in the non-government psychiatric facilities, not because duty counsel would be unable to perform the task, but of course they do that along with many other things, don't have special training beyond a very limited amount to do the job, and it just simply isn't possible to impose the same kind of requirements on people who are doing this in a way that isn't coordinated, where there isn't a really extensive amount of training or supervision of them.

It certainly doesn't need a lawyer to do it, as many people have pointed out about the existing program. The point is that the Advocacy Commission would be able to actually create a program province-wide, tailor administratively the rights advisers working in various areas, the types of facilities and so on, according to what the need was in a given place. If you didn't need many rights advisers in a certain area, it could arrange for a program delivery that would suit that and still ensure training. That's the problem: If it wasn't mandatory that the Advocacy Commission take up that responsibility if asked to do so, it would create a problem of having to create a standalone program to do it.

**Mr Sterling:** I find the reasoning very difficult to follow, to be kind. The reason that it's included, I am told, is that if the Advocacy Commission were asked to do this under a prescribed regulation, the commission might refuse. Who are we kidding? From where does the commission get its money to operate? How on earth can anyone argue that the Advocacy Commission, which is receiving its money from the taxpayers of Ontario, if asked under a regulation as decided by the cabinet of Ontario to help out people under Bill 109, would refuse? That argument I have to reject in toto.

I just find the idea of tying the hands of the government to the Advocacy Commission silly. Why would you, if you discovered that the Advocacy Commission were unable to provide the kind of rights advice which was working for vulnerable people or for anybody else under Bill 109, tie your hands to it? What would happen if the Advocacy Commission was not able to operate properly for a period of time for whatever reasons? I would hope the government would react in another way. It might want



to create another kind of commission or another kind of group to provide this rights advice.

All I'm saying is that it makes more sense to me to deal with this in as flexible a way as possible. I would only hope that the government would be able to provide this committee now with whom it is going to prescribe as rights advisers. I haven't heard that yet. Here we are, passing a piece of legislation that's supposed to become law hopefully in the next—well, I don't know how long. We haven't heard anything, because we haven't had the minister in front of us to tell us when this is going to become law, but presumably it's going to become law within a year or two. Who are going to be the rights advisers? I haven't been told that yet, and we're being asked to pass this section.

Notwithstanding that, I think the idea of including one group to the exclusion of others is wrong. I would think that the group we would historically trust most to give rights advice in this province would be lawyers, who are controlled by the Law Society of Upper Canada. They have been trained with regard to giving rights advice on issues more than anybody else in this province. If you were trying to do it in terms of primacy of qualification you would say, "I guess the lawyers trained in rights and obligations would be the first group we would put in," and then you would add on to that at a later time. That's why in one of my amendments I say, "The lawyers plus any other prescribed group."

I'm also concerned, quite frankly, with the smaller communities that are not going to be adequately taken care of by the Advocacy Commission. I have mentioned that before in previous arguments. Therefore, I want to include the lawyers to make certain that people who needed rights advice in that area in a quick and timely way would get it. I wasn't going to entrust the government to exclude the lawyers out of that group, because at least I am confident in that group of, I believe there are now, in the neighbourhood of 20,000 lawyers across the province, that you would be able to find one in an emergency, that you would be able to get one to give rights advice if it was needed.

The argument too, I want to say, from the policy person from Health about lawyers not having adequate training with regard to giving advice in this area is not a fault of the lawyers; it's a fault of the present government and previous governments in not bringing together an educational program to say to the law society, "Provide a specialization in this area." Lawyers can be specialized in criminal law or any other area of law they want, and there's nothing to prevent the law society from creating a specialty with regard to giving this kind of advice for people across Ontario.

All I'm saying is that the premise you start from in terms of rights advisers is totally wrong. It should be starting from those who we have, over a history of time, learned to go to for rights advice, and then everybody else should be prescribed in.

1440

**Mrs Sullivan:** I have problems also with the argumentation put forward by the policy adviser to the ministry. It seems to me that the Minister of Health and the

government of the day do have the authority, with this amendment, to call on the Advocacy Commission to provide, from time to time, advocates who are trained in providing rights advice. It also would provide the authority to call on people such as chaplains in certain facilities, to call on lawyers in certain areas, to call on social workers in other areas, as the case may be. The flexibility is clearly there as a result of this amendment, so I reject the view that the flexibility is not provided with this amendment being there.

I'd also like to point out that one of the interesting points, although some people don't like it, about the psychiatric patients' advocacy operations is that in fact they are not statutory. They are basically a programmatic scheme of the Ministry of Health and their work has been useful work. It was not necessary for them to have a separate surround of the Advocacy Commission. If the ministry and minister found it necessary, a similar surround could be made for rights advice. This amendment takes all those scenarios into account and has the additional positive attribute of containing the rights advisers in health care situations to the Consent to Treatment Act. The minister then has the freedom to operate beyond that.

**The Chair:** Further discussion? Seeing no further discussion, all those in favour of the Liberal motion on subsection 1(1)? Opposed?

Motion negated.

**The Chair:** Liberal motion alternate 2 on subsection 1(1).

Mrs Sullivan moves that the definition of "rights adviser" in subsection 1(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out, and the following substituted:

"'rights adviser' means a person who

"(i) is a member of a prescribed category of persons who are authorized to give rights advice in prescribed circumstances, and

"(ii) is not employed by an organization that provides housing, vocational or health care services."

**Mrs Sullivan:** This motion is put forward, one, to reiterate the arguments I previously put about the rights adviser being limited and in the surround of the Consent to Treatment Act in the first case. I also believe, frankly, that this is the understanding the minister and ministry officials gave to health care agencies in discussions with them before this bill came to the floor in its amended form.

But secondly, I want clarification from the government with respect to subclause (ii) of this amendment. We have heard a lot of rhetoric with respect to the independence and the necessity of independence of the rights adviser or advocate from the institution in which that advice is put forward. We have had conflicting information about who the rights advisers will be and who will be responsible for paying for them. This amendment is put forward to obtain clarification and a clear statement from the government of what its intentions are.

Hospitals want to know if they are going to be required to have a full-fledged staff complement of rights advisers, either new people who are brought on staff or people



whose jobs will have an alternative form of duty, and other organizations in the health care field similarly want that advice. Nursing homes want to know if under their current mandate there is going to be an additional mandate of making rights advice available. The government has not made itself clear. We want that clarification and we want it today.

**Mr Jim Wilson:** While I appreciate what Mrs Sullivan is trying to do with this amendment, we will not be supporting it. Subclause (ii) of the amendment, the way I read it, would effectively prevent health care providers and regulated health care practitioners from providing rights advice. I think that in rural areas of the province and areas that Mr Sterling said earlier in his comments that won't have an army of rights advisers readily available, it's vitally important that health care practitioners be able to carry on the status quo because we trust health care practitioners.

**Mr Wessinger:** We'll be opposing this amendment as well, for some of the reasons expressed by Mr Wilson. The fact is that we have to live in the world of what is practical as distinct from what is ideal and it's important this flexibility be in the act to not restrict.

**Mrs Sullivan:** I'd like to ask Mr Wessinger if the response he gave us last week when we were sitting with respect to the independence of the rights adviser still holds or has there been a change of mind with respect to the opinion he provided us last week?

**Mr Wessinger:** If I could clarify that, I think from an ideal point of view the independence of rights advisers is desirable, but I think that has to be tempered by the realities of providing the service. I think that's when we have to have the flexibility to combine those two considerations.

**Mrs Sullivan:** Your clarification then means that while rights advisers may be independent of an organization, you will also expect in certain cases organizations themselves to provide rights advisers on staff for patients who are in the health care process. Could I ask then who will pay for those people?

**Mr Wessinger:** I think, first of all, I should clarify to indicate there's been no decision made or the matter even considered with respect to designated persons within organizations to provide such services. The matter has not been considered or dealt with at this stage. I think it's fair to say that one could anticipate that it is possible there are existing people within some of these institutions who might be given such responsibilities, but that is a possible consideration. I certainly don't anticipate, as you indicated, the hiring of new people. I would be surprised if that was the approach that was taken.

I think the whole question of an integrated situation has to be looked at. Quite frankly, there is other legislation in the course of preparation at the moment, for instance the Public Hospitals Act, and whatever the movement is in the legislation, that area will undoubtedly relate to the consent to treatment.

**Mrs Sullivan:** Once again, the public and people who are involved in managing institutions are left with few answers. I'm going to be withdrawing this amendment. I wanted it on the table specifically to gather the information

people need to be able to understand the implications of this act. Within eight or 10 days, we've had two answers; the one today is quite different than the one given last week. Then we are told, "Well, in fact, we don't know." The government doesn't know far too much about this legislation.

1450

**The Chair:** Is it my understanding you're withdrawing the motion, Mrs Sullivan?

**Mrs Sullivan:** I've withdrawn the motion.

**The Chair:** Next, we'll move to the PC motion, alternate 1.

Mr Sterling moves that the definition of "rights adviser" in subsection 1(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"'rights adviser' means,

"(a) a person who is a member of a prescribed category who gives rights advice in prescribed circumstances; or

"(b) a member of the Law Society of Upper Canada who is willing to act as a rights adviser under this act."

**Mr Sterling:** I'm quite willing to entertain an amendment to my amendment to include the advocates under the Advocacy Act if that is the only reason the government opposes this amendment.

**Mr Wessinger:** The reason we'd oppose this amendment is because, first of all, it specifically sets out one particular group which may or may not be included. Certainly no decision has been made on who might be included in the prescribed category and prescribed circumstances.

Second, the model might be somewhat expensive if it were the model adopted of providing legal counsel. In certain exceptional circumstances, I can see it might be required, but as a general approach it would be highly expensive. The cost of lawyers is fairly high, probably much higher than other forms of delivery.

**Mr Jim Wilson:** Are not legal aid lawyers currently providing rights advice in the mental health centres?

**Mr Wessinger:** Perhaps I'll have counsel indicate the present circumstance.

**Ms Auksi:** Sorry, you didn't get counsel. Regarding the part of the program that's delivered by duty counsel under legal aid, even the director of legal aid, Mr Bob Holden, during discussions that were held at the time the rights adviser program was being evaluated, recognized that it does not require a lawyer to master the pretty limited amount of legal rights information that a rights adviser delivers, so in fact it's not necessary to have someone of that high expertise and, in a sense, it's a waste of his expertise.

What a rights adviser needs, in addition to an understanding of the limited amount of legal information, is the ability to communicate well with people of doubtful mental capacity. They have to spend the time to learn how to do that well. That is part of the consideration.

Unfortunately, under legal aid, duty counsel who have been doing this will sometimes go to a training session and maybe will not get updated to the same extent as someone



who spends more time getting specific training to do the task, who may be someone with a lesser level of skills generally but who for this purpose is perfectly fine, such as a paralegal, if you will. It's not to say that lawyers wouldn't be suitable, but it's certainly not necessary and, as Mr Wessenger suggested, for cost reasons, probably not desirable.

**Mr Sterling:** Since we've gotten into the debate about the cost of doing this, what does it cost the legal aid plan to provide these services now? I'm sure the parliamentary assistant will have that at his fingertips.

**Mr Wessenger:** I don't have that information. If you wish to obtain it—

**Mr Sterling:** I suspected you didn't, because probably you'll find that legal aid lawyers would be one heck of a bargain as compared to advocates under this Advocacy Commission in which you are creating a huge bureaucracy and are providing a \$30-million operation to provide 200 advocates. I've got to tell you that you could probably buy 600 lawyers for the same price.

**Interjection:** Already trained.

**Mr Sterling:** Already trained. I would really like to take great opposition to the whole economic efficiency argument with regard to how much it would cost to hire a private lawyer. But I want to say that the reason I consider it essential that this particular group of individuals be put into the act is that I want to protect the vulnerable person who is out in some place in Ontario after this act comes into place.

If a doctor cannot get to a rights adviser under the Advocacy Commission because the office closed at 5 pm that day and there isn't anybody else around—there's not a local number, there's nobody you can find—I want the doctor or the health care provider to be able to call somebody in that community and say, "Hey, we've got a problem here and we need somebody who's not a bureaucrat or a civil servant," as all these advocates are going to be. "We want somebody who can come down and give the advice to this vulnerable person so we can carry on the treatment of this vulnerable person right away."

That's why I don't want to have to wait for this government to say, "We are going to put these people into this group," or, "We're not." I want that guarantee in this legislation now, because this is the last chance I as a member of the Legislature will have to ensure that out in the further reaches of the province in particular, but I'm sure it will occur even in this city, vulnerable people will be able to get rights advice on an emergency basis and that our health care providers can be assured that somebody's going to be there whom they can go to when the commission's offices close at 5 pm every weekday and they are not going to be there on Sunday afternoon.

**Mr Wessenger:** Mr Sterling, I understand your concerns. The only thing I can say is that certainly, when it comes to the drafting of the regulations, those concerns will be taken into account.

**Mr Sterling:** That's fine and dandy, Mr Parliamentary Assistant, but I want to know why we can't have it in now. Why can't we?

**Mr Wessenger:** There may be other—

**Mr Sterling:** If you don't have a good reason for no, then why not now? Why can't you assure the people of Ontario out there that their vulnerable adult friend or family member is going to have an adviser, when it comes down to a critical situation where the doctor is hesitating to act because you can't get a rights adviser there? Why can we not give those people that satisfaction right now?

**Mr Wessenger:** Mr Sterling, I would suggest to you there are other people in the community who could have this rights training and who could be available in those circumstances which you indicate. There are other professions, I think, that—

**Mr Sterling:** Will you guarantee that? Will you guarantee to the people of Ontario that there will be a rights adviser available 24 hours a day, seven days a week, 365 days of the year?

**Mr Wessenger:** Mr Sterling, it's—

**Mr Sterling:** You won't, and neither will this government. Why not take a group of 17,000 to 20,000 particular individuals who are out there and trained to give this kind of advice—perhaps not as well as some other people, because they have other kinds of law which they practise—but who are basically the best trained group of individuals we have in Ontario society? Why don't we give vulnerable people this break?

**The Chair:** Mr Wessenger, a response?

**Mr Wessenger:** I understand your concerns; I just don't agree with you that lawyers are the only persons who can deliver this type of service, Mr Sterling.

**Mr Sterling:** I haven't said that. That is taking me out of context.

**Mr Wessenger:** No, but you—

**The Chair:** Mr Sterling, allow him to finish his response, please.

**Mr Wessenger:** I need to be convinced that you have to have lawyers as a last resort. That may be in the case of some instances—I don't want to say—but I'm not convinced of it, and therefore I don't think you should select and designate out a specific group in this definition. It should be dealt with in regulation.

1500

**Mr Sterling:** You want advocates out of this then? Am I to understand that you don't want to designate any group, so we'll take advocates out of this definition? I mean, you can't have it both ways.

**Mr Wessenger:** We've already been through that discussion about the role—

**Mr Sterling:** Okay, and I'm willing to put advocates in if you're willing to put lawyers in.

**Mr Wessenger:** I don't have that great deal of confidence, Mr Sterling, that lawyers are the group of last resort.

**Mr Sterling:** I just said I'm willing to put advocates in; I didn't say I was only willing to put lawyers in. I said I'm quite willing to listen to a reasonable argument with regard to other groups that might give rights advice. I'm only concerned about the vulnerable person who doesn't



have one of these other special people you're putting up, and I think there are more lawyers in Ontario than there are any other group that you can put up as potential rights advisers.

**Mrs Sullivan:** We'll be supporting this amendment. We feel it's a practical and a valuable one. The arguments Mr Sterling has put forward with respect to many of the areas of Ontario which will not have rights advisers at ready command we think is a good one.

**The Chair:** Further discussion? Seeing no further discussion, all those in favour of the PC motion on subsection 1(1)? Opposed?

Motion negated.

**The Chair:** Next, the PC motion on subsection 1(1), alternate 2. Mr Sterling.

**Mr Sterling:** This very much mirrors the Liberal amendment to this section. However, the government, as indicated by the parliamentary assistant, didn't want to designate any group. He could indicate at this point in time that he would support this amendment, having had second thoughts with regard to the first amendment, so I would wait for his response before I withdrew it.

**The Chair:** Mr Wessenger?

**Mr Wessenger:** Sorry, I was—

**Mr Sterling:** I said that this motion is very similar to the others but, following your arguments with regard to my previous amendment, I would have thought you would have second thoughts with regard to Ms Sullivan's amendment and probably would be quite anxious to support this one.

**Mr Wessenger:** I don't think it serves any useful purpose to revisit the discussion we had on the previous motion.

**Mr Jim Wilson:** If it would raise the intelligence of the discussion, it might be. We've not had reasonable responses from the government.

**The Chair:** Mr Sterling, do you wish to move this amendment?

**Mr Sterling:** No, I do not. I withdraw the amendment.

**The Chair:** Next, the Liberal motion on subsection 1(1). Mrs Sullivan.

**Mrs Sullivan:** I have two motions to subsection 1(1) which I'd like to stand down for consideration while we're dealing with section 22. Do you want me to read them into the record now or later?

**The Chair:** I prefer to have them moved now.

Mrs Sullivan moves that the definition of "treatment" in subsection 1(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out, and the following substituted:

"'treatment' means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purposes, and includes a diagnostic evaluation or a course of treatment."

Mrs Sullivan moves that subsection 1(1) of the bill, as reprinted to show the amendments proposed by the minister, be amended to add the following definition:

"'diagnostic evaluation' includes the performance of such examinations or investigations as may be reasonably necessary in order to determine whether the circumstances set out in clause 22(1)(b) exist or to form the opinion described in clause 22(2)(b)."

Do we have unanimous consent to stand down?

**Mr Jim Wilson:** I just have a comment, Mr Chairman. Given the record of standing things down in this committee and then revisiting them, which has been abysmal, and given that the government invoked closure on Bill 74, my advice to Mrs Sullivan would be, don't stand these down; you may never get back to them.

**The Chair:** Do we have unanimous consent to stand these two motions down? Agreed.

The PC motion on subsection 1(1).

**Mr Jim Wilson:** We're going to withdraw this motion since our plan of care motion, which I think was the first one debated this afternoon, failed.

**The Chair:** Do we have unanimous consent to stand down the vote on the government reprint of subsection 1(1)? Agreed.

Next, the Liberal motion on subsection 2(2).

Mrs Sullivan moves that section 2 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Emergency admission to program

"(2) This act does not apply with respect to a person admitted to a secure treatment program under section 124 of the Child and Family Services Act."

**Mrs Sullivan:** As you know, we had before us, in public hearings, representatives from children's aid societies and people who are involved in the delivery programs of the emergency secure treatment under the Child and Family Services Act. Their concerns were strong ones, and in my mind weren't particularly alleviated by the testimony from the Ministry of Community and Social Services.

While there are, through Bill 110, some references to the Child and Family Services Act, I felt that the reiteration, in this bill, of the pre-eminence of the CFSA with respect to the emergency secure treatment of children was an appropriate way to go so that there would be no misunderstanding.

As you know, the Child and Family Services Act provides children's rights, a process for consultation and a process for involvement of the children in decision-making with respect to their care as well as their health care. We felt that including this amendment simply underlined the pre-eminence of section 124 of the Child and Family Services Act.

**Mr Jim Wilson:** I think it's important that the comments Mrs Sullivan has just made be included in the historic record of the intention of section 2 of the act, yet I think it's a rather unusual precedent to start excluding all kinds of different acts from this act. The reprint clearly reads that this act only applies in respect of treatment administered by health practitioners, and it would seem to me that we might be getting on to a slippery slope here. I'd like to ask the parliamentary assistant to give us the government's opinion on this.



**Mr Wessenger:** We will be opposing this amendment on the basis that this amendment would take away all rights advice for any form of treatment from any child under 16 who is admitted to a facility mentioned under the Child and Family Services Act. We would be treating children differently in this particular type of institution from those otherwise. Although I'm not a constitutional law expert, I think treating children unequally with respect to rights advice might be considered contrary to the Charter of Rights and Freedoms.

1510

**Mrs Sullivan:** Could the parliamentary assistant then explain the dichotomy in the two laws? We will have the child and family services law on the books which says one thing and the Consent to Treatment Act on the books which says something quite different.

**Mr Wessenger:** I think I will hand this over to legal counsel, who will clarify the law with respect to the situation.

**Mrs Sullivan:** He's going to say, "Mrs Sullivan's right."

**Mr Gilbert Sharpe:** The opinion that the Ministry of Health circulated dealing with the Child and Family Services Act looks at the common law and whether it's been abrogated by that legislation and concludes that with the possible exception of section 132, dealing with psychotropic drugs, the ability of a young person in secure care in a Comsoc facility who is mentally competent to refuse treatment to so refuse is not abrogated by the CFSA. So there's really no conflict between Bill 109 and the CFSA except perhaps the provisions relating to secure-care psychotropic drug treatment under section 132. Even there it's arguable. We do waffle a bit in our opinion and there's no jurisprudence that could be found on that subject.

However, there are proposals that are now part of Bill 110 that were part of the amendments proposed by the government the last go-around that would clarify that area as well, so the provisions of Bill 109 would apply everywhere and to everyone, including kids in secure care.

**Mr Sterling:** I think we will vote for the amendment. We think it should be even more encompassing than this. We don't think this act should apply to people under the age of 16, because we're convinced by the evidence we heard in front of this committee that in dealing with adolescents, the codification of the common law and the new requirements set up under this statute are not beneficial overall to people under the age of 16. Bill 109, in my view, is an empowerment act which will allow people clear rules as to whether they consent or don't consent—capable people, but in particular incapable people, and vulnerable people as well.

My concern is that I have not heard any evidence in front of this committee that there has been any kind of abuse of people between the ages of 12 and 16 by the health care professions that we need to change the existing common law which is in place now. The problem with changing the common law by introducing rights advisers into the situation is that we are empowering people who are 12, 13 and 14, who do not have the same life experi-

ence to make decisions. In some ways, by introducing rights advisers into certain circumstances, we are taking away the rights of guardians and parents in health care decisions.

Therefore, our position is very strongly in favour of Mrs Sullivan's amendment, but we will be introducing amendments later which will in fact go further and exclude from rights advice anybody under the age of 16 in dealing with consent to medical treatment.

We know and we've heard of some situations where there are concerns about young people, particularly who are in mental health care institutions, but we believe there are adequate protections there now, and those protections can continue to be provided. But our legislation and our history of legislation in this province has been that children and young adults, if you want to call the ages 12, 13, 14 and 15 that, are different, and to try to craft acts, Bill 109, Bill 108, Bill 74, to deal with both segments of the population is wrong and is particularly harmful to this age group.

I'm sure that if the parliamentary assistant said he would agree that we would take out everyone under 16, then of course this amendment wouldn't be necessary, but we will continue to support this amendment until we have that kind of indication. So it leads into a much larger debate.

**The Chair:** Further discussion? Seeing no further discussion on the Liberal motion on subsection 2(2), all those in favour? Opposed?

Motion negatived.

**The Chair:** Next, a Liberal motion on section 3.

Mrs Sullivan moves that section 3 of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "in emergencies" in the third line.

**Mrs Sullivan:** This amendment makes the bill equate more readily with existing common law. I'd just like to point out that the same amendment was accepted under Bill 108 in our discussions with respect to that bill. It seems that it is reasonable to have the same change accepted with this bill as has been accepted for the Substitute Decisions Act.

**Mr Wessenger:** We'll be accepting this amendment, but I might indicate at this time that counsel have indicated some concern, not at least with the words "in emergencies," but a concern that perhaps a further amendment of this section and the Substitute Decisions Act might be necessary. I just thought I'd indicate that at this time. We will accept this motion for the time being.

**The Chair:** Further discussion?

**Mr Jim Wilson:** I'm just wondering what the government's opinion is. Our next amendment deals with this section and reaffirms the common-law authority. Does that help clarify some of the wording at all?

**Mr Wessenger:** No, it doesn't really.

**Mr Jim Wilson:** It certainly clarifies the intent.

**Mr Wessenger:** The deletion of "in emergencies" is much more acceptable as a solution. I'm not saying there



will be a further amendment; I'm just saying it's being considered by legal counsel; that's all.

**Mrs Sullivan:** I wonder if we could have now from counsel an indication of where the problem is here. It might be useful in discussions as we proceed.

**Mr Wessenger:** I have no objection to some clarification being given at this time.

**Mr Sharpe:** The intent of course is to provide clarification of what we're retaining in the common law and the notion of restraint is generally used only in very serious circumstances. It may be that using the term "emergency" without defining it causes other problems of interpretation, but the kind of thing we would hope to look at would be adding language before "prevent" in the fourth line like "imminent," the concept that it's not just preventing serious bodily harm, but perhaps preventing imminent and serious bodily harm, that it's a true urgent situation that would justify taking control of someone, by drugs if necessary, against his will, to restrain.

**Mrs Sullivan:** I know we shouldn't get into that debate now. If the government is intending to bring forward amendments, we'll be interested in them. We caution that restraining and confining are also necessary tools in working with people who frequently may fall out of a chair if not tied and where the emergency may not exist. So I hope issues of that nature are taken into account if the government is contemplating amendments in this area.

1520

**Mr Wessenger:** Perhaps we could have also other counsel respond to this issue.

**Ms Carla McKague:** Certainly the common-law right to restrain and confine, I think, is much less than seems to be indicated by, for instance, Mr Wilson's statement that this reiterates the common law. It is confined to urgent situations. As far as restraint and confinement for the purposes that you mentioned is concerned, Mrs Sullivan, I would have to go back to get the exact sections, but Bill 108 deals very extensively with who can authorize restraint for protection, restraint for people who do need to be restrained in a chair or in a bed for their own safety, and puts a great deal of care into defining when that is legitimate. It's certainly accepted by the government that those interventions very often are legitimate.

This section, without some sort of qualifier in it such as "imminent" or "emergency"—which may be too strong—would seem to undo the work that's gone into Bill 108 to ensure that great care is taken, that people are restrained when appropriate and not restrained when inappropriate.

**Mr Sterling:** I'm not certain of where the government is on this particular section.

**Mr Wessenger:** I think it might be fair to say that we have not made a decision on whether a further amendment is necessary at this time.

**Mr Sterling:** And you think it is.

**Mr Wessenger:** We have not made a decision; we have not considered it. It's just been raised today with me by counsel. I thought I should alert members of the committee, in case.

**Mr Sterling:** I guess my objection—not my objection; the one part I want introduced into the debate before you come up with your final wording is that section 3 now reads, "This act does not affect the common-law duty of care givers to restrain" etc. When counsel was talking about it, she said "common-law right of care givers to restrain" etc. I think the use of "duty" is kind of a strange way to draft legislation when you're talking about restraining people.

If you want to talk about "authority," which is in our amendment, I think that's more appropriate. I didn't know there was a duty to restrain people by anybody in our society. Maybe I don't know something here, that a physician has the duty to shackle somebody down in certain circumstances. I think they feel a professional obligation to do that and reluctantly do it, but I just find it a strange way to place it in the legislation, that we in the Parliament of Ontario are saying that care givers have a duty to constrain people.

**Mr Wessenger:** I'm going to turn this over to legal counsel, but before I do, I think it's clear that there is a duty that exists for care givers to restrain where necessary to protect the patient, and if they don't comply with that duty, then there is a legal obligation. I'm sure counsel may be able to elaborate more on that, but what we're putting in legislation is this fact that it's a duty. I'll ask legal counsel to perhaps elaborate on that.

**Mr Sterling:** So that duty is not criminally or statute oriented; that's a civil duty.

**Mr Wessenger:** A common-law duty, yes.

**Mr Sterling:** It's a civil—in other words, someone can sue.

**Mr Wessenger:** A civil liability test, yes.

**Mr Sterling:** I think you should use "authority." I don't think you should use "duty."

**Mr Wessenger:** Do you need to add anything?

**Mr Sharpe:** You've said it very well. I think the only thing I would add is there is a line of cases, primarily in the psychiatric field, of patients going out windows where they weren't supervised, or acting out in a way that they injured other patients or staff. Those cases, usually framed in negligence, speak of duties of care to take reasonable measures to prevent patients from harming themselves—suicide and so on—or harming others.

What we're trying to do here is retain those common-law duties that have been recognized through the years in the cases and confine them to the language of the cases where usually it's a true, very urgent, sort of emergency situation.

**The Chair:** Seeing no further discussion, all those in favour of the Liberal motion on section 3? Opposed?

Motion agreed to.

**The Chair:** I seem to have missed one in the government reprint on subsection 1(2). It's a deletion in the fourth line.

**Mr Wessenger:** The word "personal."

**The Chair:** Agreed? Carried.

Next we have a PC motion on section 3.



**Mr Sterling:** I have circulated a motion that takes into account the remarks I made about "duty" versus the word "authority," and rather than muddy the waters, what I'd like to do is propose a motion.

**The Chair:** Mr Sterling moves that section 3 of the bill, as amended and as reprinted to show the amendments proposed by the minister, be amended by striking out "duty" in the second line and replacing it with the word "authority."

**Mr Sterling:** I hope that's clear enough to everybody.

**Mr Wessinger:** I'll be opposing this amendment for two reasons. One is that if I remember all my tort law correctly, it has always referred to a "duty," so we're not using a word other than one that's recognized in law. I have some concern that the use of the word "authority" might in effect diminish the obligation of care givers. I think we clearly want to retain this obligation, this duty of care givers to restrain or confine a person and I think the word "authority" might, in the particular instance, weaken that obligation.

**Mr Sterling:** I don't know how the change in that word would differ from the common law which has been set up. I just find it strange to put in a statute what has been developed in a number of cases as to what the duties of a physician or a health care provider might be in certain circumstances.

**The Chair:** Seeing no further discussion, all those in favour of the PC motion on section 3. All those in favour? Opposed?

Motion negatived.

1530

**The Chair:** Okay, government reprint paragraph 5(1)1. Agreed?

**Mr Sterling:** We haven't passed section 4, have we?

**The Chair:** We'll go back to section 4; sorry.

**Mr Sterling:** I would prefer to stand that down until we deal with the liability section, section 24.

**The Chair:** Okay, we'll stand that down until we do section 4. Agreed? Okay, section 4, the government reprint. Comments?

**Mr Jim Wilson:** Sorry, section 4, the government reprint, we're standing that down.

**The Chair:** Oh, you want to stand down section 4.

**Mr Sterling:** Yes.

**The Chair:** I thought you wanted to stand down what we were discussing.

**Mr Jim Wilson:** No, section 4.

**The Chair:** Section 4. Okay. On the government reprint section 4, do we have unanimous consent to stand that down? Agreed.

Now on the government reprint, paragraph 5(1)1. Agreed? Carried.

The Liberal motion on paragraph 5(1)4.

Mrs Sullivan moves that subsection 5(1) of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following paragraph:

"4. The consent must not have been obtained through misrepresentation or fraud."

**Mrs Sullivan:** In my reading of the common law—in fact, a very good book which I would recommend to anybody—one of the things that is always brought forward is the question of misrepresentation. The physician may withhold pertinent information, may soft-pedal information, may present details that end up with the patient not having a full picture of either the illness or the treatment proposed. In those cases, where there have been examples in the literature, the description of that scenario is "misrepresentation or fraud." I think it's a standard part of the common law and feel it should be included.

**Mr Wessinger:** I have no particular objection to it being added, so we'll agree to it, though I think it's probably already included in the terms, for clarification purposes.

**Mr Jim Wilson:** We'll certainly support it, but we do think it's redundant also. The term "voluntary" covers that.

**The Chair:** Further discussion? All those in favour of the Liberal motion on paragraph 5(1)4? Opposed?

Motion agreed to.

**The Chair:** The Liberal motion on clause 5(2)(a).

Mrs Sullivan moves that clause 5(2)(a) of the bill, as reprinted to show the amendments proposed by the minister, be amended by inserting after "received" in the first line "orally, in writing or in any other form reflecting the special needs of the person."

**Mrs Sullivan:** This addition is with respect to the transfer of information about the treatment, the side-effects, the consequences of not having the treatment, and to ensure that the person who may have a physical impairment or who may be of a different language from the physician who is providing the information receives the information in a way that he or she can understand. This follows the pattern of both the Substitute Decisions Act and the Advocacy Act.

**Mr Wessinger:** We do have some concerns about this amendment in the sense of the obligations it might impose upon health care providers. I think I'll ask policy staff to give the concerns.

**Ms Auksi:** I think it's more of a legal question than a policy question, but lawyers never want to answer the tough ones.

**Mrs Sullivan:** With respect, Mr Chairman, I believe this is a political question and I think this should be answered by the parliamentary assistant. This is not a question the ministry officials should be put in the place of responding to.

**Mr Wessinger:** I think the purpose of asking for the response was for clarification of interpretation of what it would provide. I'd be quite happy to say that our concerns are that this would impose a subjective over an objective test, which would place the obligation upon the health care provider to ensure that the person basically would put a subjective test rather than an objective test and would make it very difficult for health care providers in the circumstances.

That's the aspect and I was only really asking policy staff to indicate that this is their interpretation. That's the only aspect, and based on their interpretation, that's the reason for not supporting the proposal, because of the consequences of the amendment.

**Mr Alvin Curling (Scarborough North):** So you're supporting it.

**Mr Wessinger:** No, opposing it.

**Mr Jim Wilson:** While I've not had a lot of time to think whether we're going to support it or not, it seems to me that Mrs Sullivan is correct in introducing it, because we had similar amendments introduced and accepted by government in the Regulated Health Professions Act in terms of disseminating information and ensuring that information was received, transmitted and understood in every form available. I think that's the intent here. At that time, last summer, it was imperative that the government have this amendment in.

**Mr Curling:** I just want to reinforce what Mrs Sullivan had said, that looking at this society, which is quite multicultural too, and also, if I dare say, our illiteracy rate is pretty high, that orally would be quite an emphasis which could be placed on getting some consent. From a political point of view, I still didn't get the reason why you would not support it.

**The Chair:** Further comments, Mr Wessinger?

**Mr Wessinger:** I would like to ask staff to indicate their interpretation of what this could require, and that would perhaps indicate the reason, substantiate the concerns.

**The Chair:** Juta, could you please come forward?

**Ms Auksi:** It's our concern that by putting that provision in here, it could somehow be construed that the health care practitioner himself or herself would somehow be obliged to provide for these means of, let's say, interpretation, of providing for information available in many languages, many special forms of communication that may be required, depending on a person's disabilities.

Although there's no argument at all with the principle that these accommodations need to be made, the question is whether it should be on the shoulders of the health practitioner to arrange for that, provide for that. As things are currently, this is often done of course within hospital facilities. There are various arrangements made for all these kinds of accommodations, but one would not necessarily want to say that whenever someone goes to a doctor that it's the health practitioner who would somehow have to scurry around and make sure that an interpreter was found, for example.

It's true, it is a policy question then: Should there be a program of that kind? I think it's a separate policy question, though, and not one that is either unique to or appropriate to be dealt with in the Consent to Treatment Act. Certainly the human rights legislation would suggest there are all kinds of obligations to ensure the communication is appropriate to the situation.

Here a doctor could not proceed without having informed consent. Obviously if a person hasn't understood the information because the communication didn't happen

in a manner that made it possible for the person to understand, then the doctor, for example, couldn't have informed consent. So the obligation is certainly there. The question is, whose responsibility is it to provide it? If that interpretation cannot be made by adding this provision, then I suppose it would be open to having that in there, but it seems to me that it is there and that's a separate policy issue.

1540

**Mr Malkowski:** I would like to move that this issue be stood down.

**The Chair:** Do we have unanimous consent to stand down this Liberal motion on clause 5(2)(a)?

Interjections.

**Mr Jim Wilson:** Make up your mind. Who's standing this down? Is Mr Malkowski standing this down? If he stands it down, we'll never see it again.

**The Chair:** Do we have unanimous consent?

**Mrs Sullivan:** No.

**The Chair:** Further discussion. Seeing no further discussion, all those in favour of the Liberal motion on clause 5(2)(a)? Opposed?

Motion negatived.

**The Chair:** A government reprint on subsection 5(2). Comments? Agreed.

Next we have a Liberal motion on subsection 5(3).

Mrs Sullivan moves that subsection 5(3) of the bill be struck out and the following substituted:

"Express or implied

"(3) Consent to treatment may be express or implied, as long as the consent complies with subsections (1) and (2)."

**Mrs Sullivan:** This is really clarification to ensure that no matter in what manner or what form the consent is provided, whether it is express or implied, there are the same provisions about the consent relating to the treatment, that the consent is being given voluntarily and that information was received about the treatment and the alternative courses of action and so on. It's really a clarification motion.

**Mr Wessinger:** We have no objection because I agree it does clarify.

**Mr Jim Wilson:** We'll be supporting the amendment.

**The Chair:** Further discussion? Seeing no further discussion, all those in favour of the Liberal motion on subsection 5(3)? Opposed?

Motion agreed to.

**The Chair:** Next a Liberal motion on section 5.1.

Mrs Sullivan moves that the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following section:

"Consent to course of treatment

"5.1 If, in consenting to a course of treatment, consent is given in accordance with this act to a treatment that is part of the course of treatment, no further consent is required in respect of the treatment that is part of the course of treatment."



**Mrs Sullivan:** This issue arose in the first round of public hearings with respect to definitions of "treatment" and "course of treatment," when there was discussion before the committee indicating that a course of treatment may include several separate scenarios with respect to the delivery of health care and different procedures which become part of the course of treatment.

There was concern expressed at the time that a separate consent would have to be given for each individual procedure although it was in fact part of the course of treatment. This motion clarifies that while the course of treatment can be specific unto itself, each individual part of the course of treatment doesn't require a separate consent.

**Mr Wessenger:** We will not be supporting it, based on the fact that legal counsel advises that it is not necessary because of the definition of "treatment." Perhaps I'll ask legal counsel to confirm that.

**Mr Sharpe:** The definition of "treatment" includes "a course of treatment" and a "plan of treatment," so that when a consent to treatment is obtained under this act, the elements in the course of treatment would be included.

**Mrs Sullivan:** If that's the case and if that's the understanding of the medical profession, why did health practitioners bring this issue forward and why were they concerned about it?

**Mr Wessenger:** I don't know why they brought it forward other than the fact that there have been misunderstandings with respect to the legislation. I think that's fair to say, particularly from the very beginning, particularly from the early drafts. But based on what legal counsel advises me, I don't see it as necessary. I also would agree with legal counsel's interpretation that once consent is given to a course of treatment or a plan of treatment, treatment may proceed with no further consent required.

**Mr Jim Wilson:** Just briefly, I agree with the advice the government's getting from legal counsel; it does seem redundant. Although it wouldn't be harmful to include it, certainly the definition of "treatment" does include "course of treatment." It all says the same thing to me.

**The Chair:** Further discussion? Seeing no further discussion, all those in favour of the Liberal motion on section 5.1? Opposed?

Motion negatived.

**The Chair:** Next we have a government motion on subsection 6(1).

Mr Wessenger moves that the English version of subsection 6(1) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "who is capable with respect to a treatment" in the first and second lines and substituting "is capable with respect to a treatment if the person."

**Mr Wessenger:** It's just minor to clear up a drafting error.

**The Chair:** Further discussion?

**Mrs Sullivan:** Can we just have a minute?

**The Chair:** Certainly.

**Mr Wessenger:** It's also needed for consistency between the English and French versions. It's on the advice of legislative counsel that this is being moved.

**Mrs Sullivan:** You're actually only adding the words "who is." Is that right?

**Mr Wessenger:** We're just taking out the word "who." Just the word "who" is being removed.

**Mrs Sullivan:** No, you're putting a "who" in.

**Mr Jim Wilson:** No, the "who" out, but it's replacing "a person" at the end really. It's a rewording.

**Mrs Sullivan:** In the first and second lines.

**Mr Wessenger:** So it reads, "A person is capable with respect to a treatment."

**Mrs Sullivan:** Oh, okay.

**The Chair:** Discussion? Carried?

Motion agreed to.

1550

**The Chair:** Next, a Liberal motion on subsection 6(1).

Mrs Sullivan moves that subsection 6(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Capacity with respect to treatment

"(1) A person is capable with respect to a treatment if the person is able to understand the subject matter in respect of which consent is required and is able to appreciate the consequences of giving or withholding consent."

**Mrs Sullivan:** This definition conforms to that of "capacity" in the Mental Health Act. The definition as it's in the bill, frankly, to me, makes no sense. The "reasonably foreseeable consequences of a decision or lack of decision" are of concern. What is of concern is the capacity to understand the consequences of saying, "Yes, I will undergo that treatment," or, "No, I will not undergo that treatment." It seems to me that for consistency with the one act and to make sense, we should accept this amendment.

**Mr Wessenger:** My problem with this amendment is that the section is in the same language as in Bill 108 and I think we should keep consistency between the two bills. I think that's the reason why we should retain the existing language, to have consistency between Bill 108 and Bill 109.

**Mrs Sullivan:** We have an opportunity to bring Bill 108 into line with this bill and with the Mental Health Act. It should be appropriate that all the bills reflect the same definition of "capacity" so that there's consistency and clarity in the approach, and the one bill that's extant and in operation now is the Mental Health Act. The definition in Bill 109, as I've indicated, makes no sense. An accompanying and comparable amendment to Bill 108 is going to be on the table. I think it should be looked at very seriously and accepted today.

**Mr Sterling:** This section relates very much to section 9 of the bill, which requires the health practitioner to apply some prescribed criteria to determine the capacity of the person. What is the prescribed criteria that the Ministry of Health has developed to determine the capacity?



**Mr Wessenger:** At this stage I think I'll call on legal counsel perhaps to make some comments with respect to the Weisstub report. Would it now be an appropriate time—

**Mr Sharpe:** I looked at Jutta and she said, "Don't you dare."

**Mr Jim Wilson:** That's what our amendment does.

**Mr Sharpe:** Several years ago, as people know, there was a study done on mental competency by Professor Weisstub and it made a number of recommendations, very good ones, on what types of criteria and procedures should be developed and applied for assessing mental competency or capacity. The ministry has been consulting with a number of groups and is developing standards and criteria. To my knowledge, these haven't been finalized as yet. The consultation process is still going on, so I don't believe there are any criteria that could be put before the committee today but I do know there's a process that's been ongoing for a while to do this.

**Mr Jim Wilson:** Just along those lines, members will know that with the PC motion dealing with subsection 6(1), there we've tried to delineate some of those criteria and that's been extracted from the Weisstub report, for the information of committee members.

We're presented really with three choices here in terms of the Liberal amendment, the government reprint and the PC motion. Given that, I think Mr Sterling has a question or comment.

**Mr Sterling:** The definition of "capacity" with respect to treatment doesn't really mean anything until you have the test. That's why we think that "capacity" should be defined in terms of what the test is going to be. That's why we've put forward our amendment. I guess it could be argued that it's a higher test than either in the existing bill or in the Liberal amendment. But it's a real test as well and I guess it has some ground underneath it.

**Mr Wessenger:** The only thing I would reiterate is that I believe we have to have consistency on these points. I think Mr Fram from the Ministry of the Attorney General probably would have some comments on this whole question of proposing the amendment, on the basis that there should be consistency between the two acts. Until there is agreed-upon language between the two ministries, we should stick with the existing definition. Mr Fram, if I remember correctly, probably would have said that the test of capacity is a more workable test, I would think, than perhaps the one set out in the PC motion which, as indicated, raises a much higher standard. I'm just trying to perhaps paraphrase the comment made. Mr Winninger might want to comment on this issue as well.

**Mr Winninger:** Certainly, as Mr Wessenger points out, it's desirable to have consistency across the statutes. We have a definition for the purpose of personal care in section 46 of the act; I don't have it with me right at the moment, but that's where we delineate our definition.

I'm a little concerned about the wording in the Liberal motion, which would suggest that the person would have "to understand the subject matter in respect of which consent is required." That could be interpreted quite broadly

and might place a higher test than is desired in the context of this particular section.

**Mrs Sullivan:** I find it interesting that the legislation which is now on the books, which is now in play in Ontario, where mental competence and capacity are an issue, is the Mental Health Act. That is the one piece of legislation people are now working with on a daily basis that includes a definition of "capacity." The definition I've included in my amendment is the same as the definition in the Mental Health Act. It is exactly the same definition.

I look at this definition that's proposed here, which says that the patient who is capable with respect to a treatment "is able to appreciate the consequences" of a decision or lack of decision. Surely what the health practitioner is interested in isn't whether or not the person is going to make up his mind, but how he's going to make it up. Are they going to say, "Yes, I want this treatment," or, "No, I don't want this treatment"? That's the issue here.

The subject matter question that Mr Winninger raises, once again, is covered by the Mental Health Act. It's the same definition as "capacity" in that act. The subject matter would clearly include the issues that are included in clause 5(2)(a), which includes the relevant information which has to be recorded or provided as a part of informed consent. That is the subject matter. It's very clear.

**Mr Sterling:** Because this particular definition was included in Bill 108, does it mean we should be consistently wrong in Bill 109 if it was wrong in 108? I don't find that kind of defence—of perhaps a mistake—a compelling argument to sway me to vote against this particular amendment of Mrs Sullivan. If she is the one who is arguing consistency with something that has been interpreted in law, probably in a number of cases because it already exists in law, then I find her arguments much more compelling than those of the parliamentary assistant. We can go back and change Bill 108 right now if we want in this committee, if there's no good reason to turn aside Mrs Sullivan's arguments.

1600

**Mr Wessenger:** I think perhaps for clarification, we have counsel here who might be able to throw some light on the matter with respect to the definition in this act and in 108. I wonder if Ms McKague could perhaps comment on this.

**Ms McKague:** Actually, what I should be commenting on, I believe, is the definition in the Mental Health Act, which is what Ms Sullivan has raised. In fact, since—I'm not sure if it's 1986 or 1987—that definition with respect to competency to consent to treatment is a two-part definition. The first part of it, which Ms Sullivan has quoted, is exactly as she's quoted in her proposed amendment. The other is in—if you've got the old numbering, I believe section 35 expands on that definition.

**Mr Winninger:** The new numbering, by the way, is subsection 49(1) in the RSO 1990.

**Ms McKague:** Then the old number 35 and the new—Mr Winninger's given you the number—reads, "In this section," which is the section dealing with consent to treatment, "and in sections 35a, 35b and 35c" "having the



ability to understand the subject matter in respect of which consent is requested' in the definition of 'mentally competent,' " which is what was quoted, "means having the ability to understand the nature of the illness for which treatment is proposed and the treatment proposed." That's it; that's simply it. That's the definition of the first part, understanding the subject matter, understanding the nature of the illness and the nature of the treatment, and then of course the appreciation part of the other test clicks in.

I could add, by the way, that this test has not yet been extensively interpreted by the courts. The issue of competency to consent to treatment under the Mental Health Act has been the subject of a very small handful of appeals and so far as I know only one at the appeal court level.

**Mr Jim Wilson:** Knowing that Professor Weisstub knew the definition in the Mental Health Act, that's why our proposal, the proposed amendment which is following, talks about the "nature of the condition for which the treatment is proposed" and the "nature of the proposed treatment."

I'm just wondering, it seems to me that the three terms used here, to loosely sum it up: It is being able to understand the information that's relevant in the government reprint. In the Liberal motion, it's being able to understand the subject matter. In ours, it's the nature of the condition or illness. Does anyone know, in legal terms, what the difference would be between those three? When Mr Winninger commented on Mrs Sullivan's, he said that understanding the subject matter might be a higher test than understanding the information relevant to making the decision. Weisstub and the Mental Health Act use the term "nature." So for arguments of consistency, one would think that our amendment, in part anyway, would hit the nail on the head a little closer.

**Mr Wessinger:** I understand you'd like legal counsel to comment.

**Mr Jim Wilson:** Sure.

**Mr Sharpe:** I can start. We have many competent counsel at the table to comment on this. It seems that the government provision in 6(1), which speaks of "information that is relevant to making a decision concerning the treatment," is very broad—any information that's relevant. Relevant to whom? I guess to a reasonable patient.

The Liberal motion, understanding the subject matter in respect of which consent is required, when we wrote the provision, I guess it was in 1978, in the Mental Health Act, we took into account language used in cases that are cited in the ministry opinion on consent, like *Johnston v Wellesley Hospital* and others. That perhaps may be a little more restrictive than 6(1), "subject matter in respect of which consent is required." The subject is surgery tomorrow, and do you have the ability—not do you actually understand but do you have the ability—to understand whatever is relevant to that surgery tomorrow?

The PC motion of course gets into specifics relating to understanding "the nature of the condition for which the treatment is proposed." You know you have an ulcer that needs surgery tomorrow morning and without the surgery there could be problems, and the nature of the proposed

treatment I assume would embrace risks associated with the treatment, because nature of the treatment narrowly taken might just be, "You're going to be put to sleep and your ulcer will be excised and this is how long it's going to take to recover from that treatment."

But one would want to read it more broadly than that, of course, because the cases speak also in terms of the ability to understand all of the risks associated with the treatment. That would be clearly embraced in the government provision of information relevant to making a decision. That would be the most broadly based net that could be cast.

As soon as we move away from that into "subject matter" and into the specific nature of this or that, one perhaps risks, since we're codifying the area here, a court saying that we have redefined *Reibel v Hughes*, *Hopp v Lepp* and some of the other decisions on informed consent and defined out certain aspects. Although we have "informed consent" defined in the bill, one would think you would then relate the capacity test to the ability to understand what is necessary to give an informed consent, and the government provision in section 6 deals with that very broadly, any information relevant to making the decision. The other provisions arguably are somewhat more restrictive.

That's my shot. As I say, there may be others at the table who would like to take a crack at the distinctions in the language.

**The Chair:** Thank you. Mr Wilson.

**Mr Jim Wilson:** I'm just wondering, with the committee's indulgence, if we could read in the PC amendment, since we're discussing it, for the record and for viewers at home.

**The Chair:** We can only have one motion at a time, unless we get unanimous consent from the committee.

**Mr Jim Wilson:** We're dealing with this sort of as a block of three anyway, I would think.

**The Chair:** Do we have unanimous consent to read in the PC motion? Agreed.

Mr Jim Wilson moves that subsection 6(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Capacity with respect to treatment

"(1) A person is capable with respect to a treatment if the person is able,

"(a) to understand the nature of the condition for which the treatment is proposed;

"(b) to understand the nature of the proposed treatment; and

"(c) to appreciate the consequences of giving or withholding consent to the treatment."

**Mr Jim Wilson:** We've been discussing this for the past few minutes. I still don't understand, although I think Mr Sharpe gave a very good explanation, but having heard the wording in the Mental Health Act that deals with the term "nature," and taking Mr Sharpe's word—and I agree that the government's reprint definition is broader and therefore a fairly low threshold test—are we being consistent with the Mental Health Act if we accept subsection 6(1) in the reprint? We're only being consistent, if I understand



your reasoning, because we're setting an even lower test than the Mental Health Act, so as long as we don't do anything tougher, we're all right.

**Mrs Sullivan:** I don't want to debate the learned lawyer, but the question of subject matter encompasses all of the issues that are included in subsection 5(2) which provide for informed consent—the information about the treatment, the alternative courses of action, the material effects, the risks, the side-effects, the consequences of not having the treatment—as well as the specific decision with respect to the action that may have to occur, which may be signing a specific consent form, having received the information, to enable a surgeon to perform surgery, which is the treatment proposed. I cannot see that by using the words “subject matter” we are limiting the content of the information that's being proposed. In fact it would be broad enough to cover any and all subject matter.

1610

The other question that I feel quite strongly about relates to the last four words in my amendment and the last five words in the government's proposal. I note that the Conservatives' proposal concurs more closely with mine. Mine says that the issue is “giving or withholding consent.” The government's drafting says the “decision or lack of decision,” which to me makes absolutely no sense at all. How is the health practitioner going to respond if the issue at hand is whether a person can or can't decide?

The issue is: Is the person going to say, “Yes, I agree to the treatment. I understand it,” or, “No, I'm not going to agree to the treatment, and let's talk about an alternative treatment”? The issue isn't decision or lack of decision, whether the person is decided or undecided. The issue is, are you going to give consent or aren't you going to give consent? Those are the issues that are of concern to the physician or any other health care practitioner.

**Mr Wessinger:** I was trying to restrain from being a lawyer, but I think I'm going to enter into this discussion just to give my own viewpoint with respect to the section.

It appears to me that subsection 6(1) establishes a much lower threshold for capacity than either of the amendments. It would appear to me that the Liberal amendment would require the person to understand all the aspects of an informed consent. On the other hand, the definition under subsection 6(1) would enable a person who perhaps may only have understood the fact that if he or she didn't have the operation, he or she might not live—he or she might be able to understand that aspect of giving a consent but might be unable to understand the aspects of the illness. To me, it gives a greater ability of individual patients to make a decision within the framework of their ability.

It's always this whole question of empowerment really, whether you want a restrictive or restricted definition of capacity or a less restrictive one. This is just, as I said, my own interpretation. I think this definition, both in Bill 108 and Bill 109, tries to give greater ability to individuals to make decisions within the frame of their own abilities to understand, as long as they can understand sufficient of the information to be able to make a decision. That's my view.

I think, as a policy matter, there is obviously a decision here to err on the side of giving people the ability to make those decisions.

With respect to a lack of decision, I think it's important there—well, whether it makes any difference between that and “withholding consent,” I don't know. A lack of decision could be just the inability to make a decision.

**Mrs Sullivan:** I'm just a little concerned about the last remarks of the parliamentary assistant, that the lack of decision could be simply the inability to make a decision.

**Mr Wessinger:** If I might elaborate on it—

**Mrs Sullivan:** The physician who's in a position of determining where next to go with the patient isn't interested in the patient's deciding or hesitating about making a decision or not making a decision. The physician's facing the person in terms of developing the course of treatment. The physician has to know whether the person agrees, whether the person refuses, and then the physician can respond in another way, either by proposing an alternative treatment or an alternative physician or whatever. Surely the point that's important for the practitioner is yes or no.

**Mr Wessinger:** If I might just elaborate, the patient may not make a decision, not because of the inability to make a decision but just because of the refusal, shall we say, to make a decision, and a refusal to make a decision would have to be construed the same way as refusing to take the treatment. Therefore, I can see the reason for lack-of-decision language, because a failure to make a decision is really construed the same as refusing to take the treatment.

**The Chair:** Further discussion? Seeing no further discussion, on the Liberal motion on subsection 6(1), all those in favour? Opposed?

Motion negated.

**The Chair:** On the PC motion on subsection 6(1), further discussion?

**Mr Jim Wilson:** I'll be withdrawing this motion and supporting the government reprint.

**The Chair:** Thank you, Mr Wilson.

Okay, do we have unanimous consent to move the government reprint on section 8? It's a deletion. We need unanimous consent to move. Agreed? Agreed.

Discussion on the government reprint section 8 deletion? Seeing no discussion, agreed? Carried.

I understand we need a brief recess before we go on to section 10, so that the interested parties can sit down and discuss this. We'll have a brief recess.

The committee recessed at 1617.

1646

**The Chair:** I call this meeting back to order. We will now be moving to section 10, the Liberal motion on subsection 10(1).

Mrs Sullivan moves that subsection 10(1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

“Finding of incapacity



"(1) If a health practitioner finds that a person is incapable with respect to a treatment, the health practitioner shall ensure that the person is advised of the finding."

**Mrs Sullivan:** Basically, this amendment reflects the discussion with respect to the age provisions and removes the age provision with respect to information that's transferred from the practitioner to the patient.

One can see, by example, that if a practitioner was speaking with a 10-year-old in terms of conveying the information that the child is incapable, in the physician's opinion, of consenting to the treatment, the physician would convey that information in a way that the child would understand and would smooth the way for the substitute decision-maker, either the parent or guardian, to come in. It reflects, I think, pretty much the sense of the Child and Family Services Act and provides a consistency within this act.

**Mr Wessenger:** We'll be opposing this amendment because, in effect, it would impose quite an obligation on health practitioners. Particularly, I think even a three-year-old would have to be advised. I think we've clearly set out the 12-year age limitation, so for that reason we'll oppose the amendment.

**Mr Jim Wilson:** For similar reasons, I'll be opposing this amendment also.

**The Chair:** Further discussion? Seeing no further discussion, all those in favour of the Liberal motion on subsection 10(1)? Opposed?

Motion negatived.

**The Chair:** The Liberal motion on subsection 10(1).

Mrs Sullivan moves that subsection 10(1) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "twelve years" in the second line, and substituting "sixteen years."

**Mrs Sullivan:** Mr Chairman, this section, as you know, the entire section of the bill, relates to the provision of rights advice which is mandatory for people who've been determined to be incapable. We heard some pretty convincing discussion from practitioners at the Hospital for Sick Children, by example, who provided us with examples of where the intervention of a rights adviser with a person who is a child and who may be in a physical situation in which fear is conditioning the judgement with respect to consent could refuse or could question the fact that he or she is considered to be incapable—a rights adviser would automatically intervene in that circumstance.

I give you the example of a child perhaps with a malformed spine, who understands, because of pain that has accompanied previous operations to correct that problem, that the proposal for subsequent operations may indeed bring with it additional pain. The practitioner who has determined the child is incapable of making that decision alone would clearly be involving the parent or guardian in a relationship that would be really a triumvirate, and in fact it may be more than a triumvirate. But the triumvirate would be the child, the parent and the practitioner discussing the issues.

The parent ultimately would have the responsibility under the Substitute Decisions Act to provide formal con-

sent, but when the determination of incapacity brings an automatic right to another intervenor who provides rights advice, we see that the trust of the working group, the triumvirate as I've called it, can be broken down, that the child would see another way out of the pain, which could be imminent, another way of postponing what in fact on the best medical evidence is in the child's best interests.

I was quite impressed with much of the presentation from the Hospital for Sick Children physicians. I think one of the things they underlined with us was the value and necessity of the trusting relationship between the physician and the patient and the working group relationship between the physician, the patient who is a child and the parent. For that reason, I think it's rational to move the automatic rights advice to the age of 16 so that the practitioner can continue working in that trusting relationship with the involvement of the parent and guardian in decision-making without the extra intervenor, which can in fact be an impediment to the provision of the finest medical care available for that child.

**Mr Jim Wilson:** Committee members will note that this Liberal amendment is exactly the same as the PC amendment on subsection 10(1). I just want to point out for the record that the only opposition party that's consistent here is the PC. It doesn't make sense to me that the Liberal Party would have introduced the previous amendment, which really would have pertained to persons of all ages, and then come in with a similar amendment or the exact amendment to ours that had already been tabled. They brought theirs in later this afternoon.

Hence, we'll be supporting the Liberal motion but want to point out, I think in fairness, that we've been consistent. Mr Sterling said early on in these hearings that we really are only supportive of this legislation if it pertains in terms of rights advice to those 16 years of age and up.

**Mr Sterling:** I want to say that I think the government should seriously consider this amendment, because I believe we would not have taken this position had we been able to somehow hear a balance of evidence which said that the empowerment of young people between the ages of 12 and 16 would seem to be done in a rational, logical way for the overall good of that age group.

It's just after hearing the evidence dealing with that immature group that we came to the conclusion it was wrong for us to try to include in the same category of empowerment those people in that age group and deal with them in the same manner as we deal with adults, as appears to be the case in this statute.

I know there are some differences, but the differences, in my view, don't measure up to the evidence we heard. I just don't understand the desire of the government to enter into this period of time in people's lives and introduce conflict between families, their siblings, their kids, their children, to have the state involved to that degree. I really think it's a mistake.

**Mr Wessenger:** We'll be opposing this amendment, because it's clear policy of our government that children at the age of 12 years and more should be entitled to rights



advice. Somehow I find some inconsistency in saying that children 12 years of age and more should not be entitled to rights advice under this act, when at the same time we give them rights and impose obligations under the Young Offenders Act. It seems logical that we should have consistency in dealing with children and having a common approach with respect to rights and obligations and with respect to ages.

**Mr Jim Wilson:** I think the public should be aware that the NDP cabinet took the decision some time ago that rights advice would be made available to persons 12 years of age and up rather than our preference of 16 years of age and up. In light of the public hearings we've had, the children's aid societies, children's hospitals and the number of groups that came forward that really helped convince Mr Sterling and I to introduce the position of 16 years of age, I would like to know from the parliamentary assistant why the government would take that decision.

I suspect the decision was taken more along the lines of empowerment, without a full understanding of how this can affect our health care system and indeed those children between the ages of 12 and 16. I'd like a further explanation, because I think it's very important. This section will be problematic in the future and the public will have a right to look back at the Hansard and see what the thinking of the government of the day was.

**Mr Wessinger:** If we look at the whole common-law situation with respect to the age of capacity, it's clear that there's no particular age set out with respect to the capacity of children. We also heard very compelling presentations that many children 12 years and up have the capacity to make decisions. If the child has the capacity to make decisions, and perhaps most children in most circumstances would have that capacity, it would seem not proper to deny a group, children between the ages of 12 and 16, the rights that adults have. It doesn't make sense to differentiate, to discriminate against a particular group of people because of a particular age level.

One could argue that we've been criticized for setting 12 years as a minimum standard for rights advice by some groups, but I think that was a practicality. We also heard evidence that 12 years of age perhaps is the age at which most children would have capacity, or a large number of children would have capacity, to make most decisions, and it seemed reasonable in a certain sense to use 12 as the cutoff age in these circumstances.

1700

**Mrs Sullivan:** In response to the comments from the parliamentary assistant, I'd like to point out that subsection 10(13) indicates that a person of any age is entitled to make an application to the board under section 26. The rights advice kicks in after the person has been determined as being incapable of making a decision.

As this act is currently written, the rights adviser is to advise the person on a mandatory basis that he has the right to make an appeal. Under the provisions of this act, the person who is 11 or 6 in fact can appeal to the Consent and Capacity Review Board. That is not left out; it is not off the table as far as a younger person is concerned.

What I'm very concerned about is the relationship of trust. I believe that the relationship between the physician and a child between zero and any age, frankly, is and should be one of trust, and that that relationship of trust can in fact be broken down when there is an automatic third intervenor who becomes a party to the treatment decision but who is without any responsibility in terms of the delivery of the treatment.

Indeed, the treatment can be impinged upon by the involvement of the rights adviser who when called in can say, "Yes, but you have the right to appeal your incapacity." Indeed, the group relationship of parent, child and practitioner can be seriously broken down and medical treatment interfered with. The right to appeal to the board is clearly available to anybody of any age. The mandatory advice, which involves a human being outside of the consultative process with respect to medical care, can become a factor that impedes the appropriate delivery of medical care.

**Mr Sterling:** I don't know whether Mr Wessinger wanted to respond to Mrs Sullivan, but I'm quite willing to postpone my remarks until he does.

**Mr Wessinger:** I'd like to comment with respect to subsection 10(13) regarding the right of a person of any age to make application to the board. In most cases, it's not really a very substantial right. It would probably only come into effect at such stage where, for example, an advocacy group such as Justice for Children might be brought in in a particular difficult situation. In other words, in real terms, there basically is no practical right for the child under 12 without the rights advice being given. I think that's fair to say.

I have great difficulty understanding the objection to giving rights advice to a 12- or a 13- or a 14-year-old child, because it would seem to me, as was suggested in the evidence of Justice for Children, that what would normally occur in a treatment situation is if a child, first of all, said he didn't want the treatment, the health practitioner would have the child discuss the matter with the parents or another physician. So after all processes had been exhausted with respect to trying to convince the child with respect to the treatment, and the child still insisted after that group discussion or the discussion with the parents, only at that stage would the rights adviser come into play. I would see this legislation working in that way. That certainly was the way the Justice for Children indicated it felt the legislation would work. I find it very difficult to understand why the opposition parties would object to a child having those rights in those circumstances.

**Mr Sterling:** There are reasons why you wouldn't understand. Basically I think you view the world very much differently than we do.

First of all, let me say that Justice for Children, in my view, doesn't represent very many people in this province. In fact they are a group of lawyers, as I understand it, who are paid by the government to represent children, usually in pretty dire circumstances, and, in my view, don't represent anywhere near the mainstream of Canadian or Ontario society. I don't know how large their organization is, but I



suspect it's very small. Therefore, for you to rely on their testimony in front of this committee is giving a great deal of credibility to a very minor point of view in this province.

Second, we do not deny that young people should have rights advice, but what we have concern with is what spins out of getting rights advice, that is, a delay, an appeal procedure, a delay to treatment of our young people, which can be very damaging to them.

We were particularly impressed with the Youthdale Treatment Centres testimony in front of this committee, whereby combining the rights of young people to appeal under these acts together with the right to appeal under the Mental Health Act and the Child and Family Services Act effectively would block treatment to some of the most troubled young people in our province for the period of time that Youthdale would have them in order to give them treatment.

It's not the rights advice that we complain about; it's the access to an appeal procedure which will drag out the time between the confrontation of the health care provider and the treatment taking place.

Third, we believe very strongly in the role of the family and the other part of the community to take a more active role in the decision-making of a person who is 12, 13 or 14 years of age than we do when a person reaches the age of 16, 17, or 18. We had psychologists and psychiatrists come before this committee and tell us that while those people who are 12, 13 or 14 can reason, their decisions lack the maturity of experience in order to determine what is best for them in the long run.

I take that expert evidence and I ask myself, should we be creating the same model of consultation of rights advice for 12-, 13- or 14-year-olds as we are for people who are 16, 17 and 18 who have the experience of life to determine if they should have that treatment and the detrimental effects on their lives if they don't accept that treatment?

That's where we draw our line. We don't draw it on the basis that you'd like to paint us as saying that people 12, 13, or 14 are entitled to advice as much as somebody who is older. Nobody on this committee, I don't believe, in the opposition would say we should deny anybody knowing what their rights are. But what we're saying is that somebody else has to be involved in that decision.

We believe that the state is abrogating some of its responsibility to young, inexperienced people by setting forth the rules for consent for those young people in the same terms as we are for adults in our society. We think you're doing a great deal of harm to 12-, 13- and 14-year-olds by including them under the same appeal procedures so they can drag out the time between their confrontation between the health care provider and treatment.

We believe that the balance between treatment and consent might be more accurately reflected for adults in this legislation than it is for young people. We believe you put far too high, in the case of 12- and 13- and 14-year-olds, the whole issue of consent versus what we as society owe them to treat them for their immediate health care problems. That's why we think it should be 16.

#### 1710

It has nothing to do with whether or not somebody sits down and speaks to them and advises them about their rights. It has to do with the way of getting a kid to proper medical treatment. I urge the parliamentary assistant to go to his minister and ask her if she really understands what the effects of putting this age at 12 are.

It's the appeal procedure, it's the duplicity of appeal procedures, and the fact that you're stalling the time between the time when the kid is there and when he's going to get treatment. You're also treating him the same as you are an adult and you're saying the 13-year-old has the same wisdom as somebody who has an experience of life or three or four more years.

We've heard in front of this committee that in most cases that magic age is around 14, when they start to lose their immaturity. I think we should take the results of the expert evidence we had in front of this committee and say, "Okay, let's err on the side of being helpful to these kids and say 15 is the age." That's why we have it under 16 and that's why we very strongly support this amendment and we have the exact same amendment in front of you.

We're going to raise this issue again in committee of the whole House. This is one issue in which we think this legislation should be fought very strongly. Quite frankly, I think you should really seriously revisit this. I don't care whether your cabinet made that decision six months ago. I didn't know what I know now six months ago. It's unfortunate your minister wasn't here to hear that testimony, but we were and we will continue to push this amendment very strongly.

**Mrs Sullivan:** Once again, as we're continuing this discussion, the parliamentary assistant has indicated he doesn't understand why the opposition opposes the automatic rights adviser at age 12. What we see as a result of this process, the intervention of the rights adviser, is that it implies an independence of action at all ages between 12 and 16, or 12 and over, in all cases.

We have certainly under the law treated children very differently, according to various levels of maturity as they're seen by society at the time. Whether it's the age of driving, whether it's the age of majority, whether it's the age for legal drinking, there are provisions in many acts that in fact specify different ages because there is a recognition in law of varying levels of maturity and understanding of the responsibilities associated with the laws and the rights to do things or not to do things.

In this case, the automatic intervention of the rights adviser and hence the appeal process availability, information about the appeal process, implies that in every case the child of 12 is open to a separate, independent action with or without the maturity. If we go back and look at the professional judgement that has been exercised in determining the capability of the child, it is professional.

The professional judgement has been made on the determination as to whether the person can understand the illness or disease, the treatment that's proposed, the consequences of not having that treatment, of the side-effects of having that treatment and those are the bases on which—as we discussed in the discussion on capacity, they are part



of the information which the capable person must understand. The professional practitioner has made a professional determination that a person of 13 perhaps is not capable in that circumstance of understanding the full consequences of providing consent and the practitioner wants to involve the substitute decision-maker in providing that consent.

We know that a child of 14 may make a decision, depending on the circumstances, to look to the appeal process for fear of pain, for fear of the risks associated with a particular procedure. A child may be told he may walk with a limp. He may be told there will be other physical ramifications that will be visible. The child may refuse or request the appeal process out of fear of social issues that he would face in the classroom or in his neighbourhood, whether it's the fear of people laughing at him because he's wearing training shoes or whether it's the fear of looking different because he has train tracks.

What we see here is the assumption that the independence of action should occur in all cases, at all times, and will be available despite the professional judgement that's been made with respect to the capacity of the person.

**The Chair:** Further discussion? Seeing no further discussion on the Liberal motion on subsection 10(1), all those in favour?

**Mr Jim Wilson:** Could we have a recorded vote?

**The Chair:** A recorded vote.

The committee divided on Mrs Sullivan's motion, which was negated on the following vote:

#### Ayes—4

Miclash, Sterling, Sullivan, Wilson (Simcoe West).

#### Nays—5

Carter, Morrow, Sutherland, Wessinger, Winninger.

**The Chair:** I take it the PCs don't want to introduce their next motion.

**Mr Jim Wilson:** Mr Chairman, given that our next motion is exactly the same as the one just defeated, we'll withdraw.

**The Chair:** Thank you. Next we'll go to the PC motion on subsection 10(2).

Mr Jim Wilson moves that subsection 10(2) of the bill, as reprinted to show the amendments proposed by the minister, be struck out.

**Mr Jim Wilson:** Essentially, our concern is with the government amendments to subsections 10(2) and (3), that health practitioners who work in a psychiatric facility or prescribed health facility will have one set of rules to follow and health practitioners who work in places other than a psychiatric health facility or prescribed health facility will have to follow a different set of rules.

We would argue that this act is already overly complex and that different procedures for hospitals, prescribed health care facilities, psychiatric facilities and other community settings will add to this complexity. What we're driving at here is some cooperation so it isn't the place of treatment that's the determining factor but the kind of treatment a patient receives.

**Mr Wessinger:** We'll be opposing this motion because it would take away existing rights, in fact, rights that had been introduced by Minister of Health Larry Grossman under the previous Conservative government.

**Mr Jim Wilson:** Look where he is today.

**Mr Kimble Sutherland (Oxford):** On a phone-in show.

1720

**Mr Jim Wilson:** I won't belabour the point, although it does seem strange to us that the government's decided to construct this legislation in the manner it has. It just doesn't seem consistent. It seems unfair to health care practitioners in terms of the confusion that this section of the legislation may lead to.

I say that in light of the fact that we've seen no true commitment on behalf of the government, as pertaining to Bill 109, to an education program for the College of Physicians and Surgeons and the members of the Ontario Medical Association.

**The Chair:** Further discussion? Seeing no further discussion, we'll proceed to the vote on the PC motion on subsection 10(2). All those in favour? Opposed?

Motion negated.

**The Chair:** The Liberal amendment on subsection 10(2).

**Mrs Sullivan:** I have a couple of amendments on 10(2). Am I to understand that because the age motion under 10(1) has been defeated, the amendments with respect to age on 10(2) and 10(3) should not be put forward? I'd like to put them forward unless they're now considered to be out of order.

**The Chair:** Go ahead and move them.

Mrs Sullivan moves that subsection 10(2) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "twelve years" in line three, and substituting "sixteen years."

**Mrs Sullivan:** I think it's clear that the discussion on this motion will be as it was on the last.

**Mr Wessinger:** We will be opposing it as we did the last one.

**The Chair:** Seeing no further discussion, we'll proceed to the vote on the Liberal motion on subsection 10(2). All those in favour? Opposed?

Motion negated.

**Mrs Sullivan:** My second amendment is to subsection 10(2).

**The Chair:** Mrs Sullivan moves that subsection 10(2) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "or prescribed health facility" in the first and second lines.

**Mrs Sullivan:** We had a lot of discussion with respect to this issue during the course of hearings, and I think it became very clear that the morass of rules that physicians would have to face in implementing this act—the guidebook would be close to 1,000 pages long if we have different controlled acts requiring rights advice in different settings if determination of incapacity has been made. The



confusion is one that's a created confusion and not a necessary confusion.

I used, in the discussions, the example of a pelvic examination, whether it occurs in whatever health setting or at home or in a home care institution, and if I, as the patient, am determined to be incapable of making a decision whether to proceed or not with that treatment, the decision should not be made on the basis of facility. The act is intrusive wherever it occurs and if I'm incapable to make a decision in one location, I am also incapable to make a decision in another location.

**Mr Jim Wilson:** Speaking to this particular Liberal amendment, I find it passing strange that the Liberal Party would have opposed the previous PC amendment which would have struck out the section, really the offensive section, based upon the same arguments for both subsection 10(2) and subsection 10(3), based upon the same arguments that Mrs Sullivan has just put forward. I make note of that lack in consistency. I do it with respect, but I find it passing strange.

Having said that, our preferences, as members will note with the next amendment coming forward, is to simply strike out this section, to strike out subsection 10(2) so that determination is made not dependent upon the place where that determination is made, but upon the treatment.

**Mr Wessenger:** We're prepared to accept this amendment because we have no intention of prescribing health facilities.

**Mr Jim Wilson:** You have no intention of prescribing health facilities, so you're going to delete it anyway.

**Mr Wessenger:** That's right.

**Mr Jim Wilson:** Well, there's a powerful amendment.

**The Chair:** Further discussion? Seeing no further discussion, all those in favour of the Liberal motion on subsection 10(2)? Opposed?

Motion agreed to.

**Mr Jim Wilson:** Mr Chair, we'll withdraw the next amendment.

**The Chair:** It was already voted on, Mr Wilson.

**Mr Jim Wilson:** Was it voted on? It's probably defeated.

**The Chair:** Next the Liberal motion on subsection 10(3).

**Mrs Sullivan:** Mr Chairman, you'll be familiar with the gist of this motion.

**The Chair:** Mrs Sullivan moves that subsection 10(3) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "twelve years" in the third and fourth lines, and substituting "sixteen years."

**Mrs Sullivan:** The discussion is as it was before.

**Mr Wessenger:** We'll be opposing this amendment, as before.

**The Chair:** Seeing no further discussion, all those in favour of the Liberal motion on subsection 10(3)? Opposed?

Motion negatived.

**The Chair:** Mrs Sullivan moves that subsection 10(3) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "or prescribed health facility" in line 2.

**Mrs Sullivan:** The argument with respect to this motion is as it was with respect to subsection 10(2).

**Mr Wessenger:** We'll be accepting this amendment. Motion agreed to.

**The Chair:** Next is the Liberal motion on subsections 10(2), (3), (4) and (5), alternate 1.

**Mrs Sullivan:** Mr Chairman, I hope you'll note the difference from the way it's printed on the agenda. I'm taking out subsection 10(2).

**The Chair:** Mrs Sullivan moves that subsections 10(3), (4) and (5) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Notice of rights

"(3) If a health practitioner finds that a person who is twelve years of age or more is incapable with respect to a treatment that is a controlled act within the meaning of subsection 27(2) of the Regulated Health Professions Act, 1991, other than a prescribed controlled act, the health practitioner shall ensure that the person is given a written notice (which may be in the prescribed form) indicating that the person is entitled to request a meeting with a rights adviser and is entitled to make an application to the board under section 26."

**Mrs Sullivan:** Basically, this draws the amendments with respect to the conveyance of rights advice to the patient via a prescribed form from the practitioner. It removes the automatic obligation to notify the rights adviser under clause 10(4)(b). Clause 10(4)(a) would stay because subsection 10(2) remains in.

Furthermore, later on in the amendments as they're proposed, I will be putting forward an amendment that would provide to the Minister of Health the requirements for regulations which would designate the prescribed form of the notification to the person of his or her entitlement to meet with the rights adviser or to make an application to the board.

1730

**Mr Wessenger:** We'll be opposing this motion because I believe there's going to be a later motion with respect to 10(3), which we probably will be moving an amendment to, which I think would form the basis of perhaps an acceptable amendment. We're opposing this motion because we want to deal with the PC motion later to be moved.

**The Chair:** Just for clarification for the members, it appears that the Liberal motion is the alternative 2a. That's the one that was moved.

Further discussion? Seeing no further discussion, all those in favour of the Liberal motion on subsections 10(3), (4) and (5)?

**Mrs Sullivan:** Mr Chairman, before we take the vote—I'm sorry; I know you're already in the middle of the vote—would it be useful to stand this one down as we

look at the next section, because I think it does fit with some of the amendments that are coming forward, while we just look at them carefully.

**Mr Wessenger:** I have no problem standing this down.

**The Chair:** Do we have unanimous consent to stand this down?

**Mrs Sullivan:** I think there is an interrelationship between that one and a couple of them that are coming up.

**The Chair:** Agreed? Thank you. We'll go to the next PC motion on 10(3).

**Mr Jim Wilson:** I should let members know that I'll be omitting a couple of words from what appears now in written form and that is the requirement of the health practitioner to read and then give written notice. I'll be deleting "read and is then."

**The Chair:** Mr Jim Wilson moves that subsection 10(3) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Notice of rights

"(3) If a health practitioner finds that a person who is sixteen years of age or more is incapable with respect to a treatment that is a controlled act within the meaning of subsection 27(2) of the Regulated Health Professions Act, 1991, other than a prescribed controlled act, the health practitioner shall ensure that the person is given a written notice (which may be in the prescribed form) indicating that the person is entitled to request a meeting with a rights adviser and is entitled to make an application to the board under section 26."

**Mr Jim Wilson:** I think the rationale stands as far as we're concerned, but Mr Wessenger wants to make a comment.

**Mr Wessenger:** I'm wondering if you would put back in the words "read and is then given," as in your original draft.

**Mr Jim Wilson:** I thought that was somewhat problematic—I don't mind doing that—because I thought it was going to be more palatable if I took that out, but if the government wants it—

**Mr Wessenger:** It would be more agreeable with it in because there is the concern of a person who would not be able to read.

**Mr Jim Wilson:** Sure. If that's acceptable, I'd like to put that back into the motion, so the motion would appear as written before you.

**The Chair:** Could you re-read the motion, then, Mr Wilson, please.

**Mr Jim Wilson:** The whole kit and caboodle?

**The Chair:** Yes.

**Mr Jim Wilson:** I move that subsection 10(3) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Notice of rights

"(3) If a health practitioner finds that a person who is sixteen years of age or more is incapable with respect to a

treatment that is a controlled act within the meaning of subsection 27(2) of the Regulated Health Professions Act, 1991, other than a prescribed controlled act, the health practitioner shall ensure that the person is read and is then given a written notice (which may be in the prescribed form) indicating that the person is entitled to request a meeting with a rights adviser and is entitled to make an application to the board under section 26."

**The Chair:** Discussion?

Mr Wessenger moves that PC motion with respect to subsection 10(3) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "sixteen" in the second line and substituting "twelve."

**Mr Wessenger:** The purpose of the amendment is because it's consistent with all the other sections that rights advice should be at the age of 12.

**Mrs Sullivan:** The amendment that has been put by the government now more closely accords with alternate 2a, which I put forward. However, I just find it interesting that when we were dealing with the section about how information with respect to the treatment and with respect to the illness would have to be conveyed to a person, the government would not take into account any of the special needs of an individual. Now, when we're in a situation where a person is being given rights advice about appealing capacity, the government has a different standard. The government has a standard that is very different in terms of what the level of understanding and appropriateness of the conveying of information is to a patient about what's wrong with them and how it's going to be fixed than it does about how they can appeal their status of incapacity. There is something wrong here.

**Mr Jim Wilson:** Dealing with the government's amendment to the PC motion, it comes as no surprise if I indicate that I cannot support the amendment, because it again lowers the age to 12, but I appreciate the small degree of compromise that's been made in this area. I see the point that Mrs Sullivan is making in terms of the inconsistency and perhaps that's something that can be worked out before all is said and done on this legislation.

**Mrs Sullivan:** Can I just ask a question for clarification? Can a statute provide direction to a physician or a nurse or a dentist as to how information must be conveyed, specifying that it must be read or it must be written, and how does one prescribe a form that is oral?

**Mr Wessenger:** We're just having some discussion with legal counsel on this motion. I wonder if we might stand it down or recess for three or four minutes. I think counsel would like to make some comments.

**Mr Sharpe:** The PC motion, it was pointed out to me, deletes in subsection 10(3) "in a place other than a psychiatric facility." We've already got provision for a psychiatric facility in subsection 10(2). Here we're dealing with other sites and controlled acts, so with the other motions having been defeated, perhaps those words should be put back into the motion to make subsections (2) and (3) consistent in the section.



1740

**Mr Jim Wilson:** With a large degree of hesitation, I would agree to do that with the motion, so it would be a friendly amendment. Given that all efforts to convince the government of the errors of its ways are failing, I do want to see some sort of compromise in this area. So I'd be prepared to accept that amendment, and I understand the point made by counsel.

**The Chair:** We would need unanimous consent for this. Do we have unanimous consent? Agreed.

Seeing no further discussion on the amendment, all those in favour of the amendment? Opposed?

Motion agreed to.

**The Chair:** On the main motion, as amended, further discussion? Seeing no further discussion, on the PC motion on subsection 10(3), as amended, all those in favour? Opposed?

Motion agreed to.

**The Chair:** On the Liberal motion, the replacement, subsection 10(4).

Mrs Sullivan moves that subsection 10(4) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Notice to rights adviser

"(4) A health practitioner who finds that a person who is twelve years of age or more is incapable with respect to a treatment shall ensure that a rights adviser is notified of the finding if the treatment is a controlled act within the meaning of subsection 27(2) of the Regulated Health Professions Act, 1991, other than a prescribed controlled act, and the person requests a meeting with a rights adviser."

**Mrs Sullivan:** I think this is self-evident. It provides the direction to the health practitioner to give information to the patient when the patient wants to meet with a rights adviser, pursuant to the previous section. It takes out the confusion we've had earlier with the bill with respect to prescribed facilities, and it is rational.

**Mr Wessenger:** I think I'm going to ask counsel to ask for another friendly amendment here, if I might have counsel explain.

**Mr Sharpe:** It seems that clause 10(4)(a) would still have to remain, since subsection 10(2) remains. If the finding is made in a psychiatric facility—and then one might want to take out "or prescribed health facility," since those deletions were made earlier—then one would still have to notify the rights adviser to go into the psychiatric hospital. So this motion might be an amendment to replace (b).

**Mrs Sullivan:** I disagree with that. I think the rights adviser is notified if the person requests a meeting with the rights adviser, no matter where the request is made.

**Mr Sharpe:** Can I speak to that?

**Mr Wessenger:** Yes, certainly.

**Mr Sharpe:** The intent of the current practice, as I understand it, was that if a person in a psychiatric facility, a patient, is found to be incapable of making a treatment decision, then a rights adviser would visit him and tell him what his rights are, whether he requests it or not. I believe

that's current practice that's being codified in 10(4)(a). If (a) were deleted, this would change the current practice so that psychiatric patients found to be incapable by a practitioner would not have an automatic rights adviser visit any longer. It would only be where they requested it, which, as I understand it, is not the present practice.

**Mr Wessenger:** Perhaps we might ask the other counsel to clarify. Ms McKague?

**Ms McKague:** Certainly the current practice—and I believe it's actually in the act; I'd have to check—is that on any declaration of incompetency to consent to treatment, or any other declaration of incompetency, for that matter, there is an automatic rights adviser visit in psychiatric facilities.

**Mrs Sullivan:** It's not statutory. It may be the practice, but it's not statutory.

**Ms McKague:** I believe there's a requirement for notification, and the practice is certainly that there is an automatic visit.

**Mrs Sullivan:** I think there was nothing that would be in conflict between the amendment I put forward, the Mental Health Act requirements and the current practice. There's no inconsistency.

**Mr Wessenger:** I might have counsel reply.

**Mr Sharpe:** I believe that's correct; it wouldn't change the current practice or the present provisions under the Mental Health Act. I believe that all (a) was doing was to codify existing practice and to create a statutory obligation for the rights adviser to visit in a psychiatric facility.

**Mrs Sullivan:** I'm interested in this, and I frankly don't want to delay this for an awfully long period, but it seems to me that the Psychiatric Patient Advocate Office is in fact doing a different job than simply providing rights advice. We are talking here about a rights adviser who is providing rights advice with respect to an appeal of a capacity determination to the Consent and Capacity Review Board. The PPAO, working under the minister's program, has a different function.

**Mr Winninger:** Just to take the London Psychiatric Hospital as an example, there's a rights adviser there as well as a patient advocate. The rights adviser merely comes in and tells the patient that he has the right to a review board and a right to be represented and a right to apply for legal aid, but there's a distinct individual there called the patient advocate who does advocacy proper.

You say that the role of the rights adviser goes beyond that contemplated here. I don't really follow your argument.

**Mrs Sullivan:** No, I said the PPAO. The rights adviser in a psychiatric institution is legal aid, right?

**Mr Wessenger:** I see maybe counsel would like to make—

**Ms McKague:** Actually, I want to make an addition to my previous response. Although the automatic visit is not in the statute, it is in fact in the regulations. Form 33 under the Mental Health Act, which is prescribed by the regulations and which is the notification to the patient of his or her

incompetency to consent to treatment, says in part, "After you receive this notice, a person called a rights adviser will be in contact with you to inform you as to your rights and help you in applying for a hearing if that is what you wish to do."

**Mrs Sullivan:** I think nothing would change in respect to that unless there is a comparable change made to that particular section in Bill 110.

1750

**The Chair:** Further? Mr Wilson.

**Mr Wessenger:** I think perhaps we'd better stand this one down so counsel can clarify it. I think it's probably best in the circumstances.

**Mr Jim Wilson:** I'd agree, Mr Chairman. While they're at it, can they reconsider the age?

**The Chair:** Do we have unanimous consent to stand this Liberal motion on subsection 10(4) down? Agreed? Stand it down.

Liberal motion on subsection 10(4).

**Mrs Sullivan:** Yes, there's another one.

**The Chair:** Mrs Sullivan moves that subsection 10(4) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "twelve years" in the second line and substituting "sixteen years."

Discussion?

**Interjection:** Same arguments.

**The Chair:** Same arguments?

**Interjection:** Yes.

**The Chair:** Seeing no further discussion, all those in favour of the Liberal motion on subsection 10(4)? Opposed?

Motion negatived.

**The Chair:** PC motion on 10(4).

**Mr Jim Wilson:** Mr Chairman, for the record, I will let this motion stand even though it's identical to the Liberal motion that's just been stood down in all terms except the minimum age requirement.

**The Chair:** Mr Wilson moves that subsection 10(4) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Notice to rights adviser

"(4) A health practitioner who finds that a person who is sixteen years of age or more is incapable with respect to a treatment shall ensure that a rights adviser is notified of the finding if the treatment is a controlled act within the meaning of subsection 27(2) of the Regulated Health Professions Act, 1991, other than a prescribed controlled act, and the person requests a meeting with a rights adviser."

**Mr Jim Wilson:** Mr Chairman, you'll note in my reading that I've taken out the words "objects to the treatment or." I note that the Ontario Dental Association wanted a clarification of that terminology and I think it's best to just drop that terminology. Having said all that, I don't expect this amendment is going very far.

**The Chair:** Thank you, Mr Wilson. Discussion.

**Mr Wessenger:** We'll be opposing, again because of the age.

**The Chair:** Further discussion?

**Mr Jim Wilson:** I'd like a recorded vote, Mr Chairman.

**The Chair:** Seeing no further discussion, we'll proceed to the recorded vote. All those in favour of the PC motion on subsection 10(4)?

The committee divided on Mr Jim Wilson's motion, which was negatived on the following vote:

**Ayes—3**

Curling, Sullivan, Wilson (Simcoe West).

**Nays—6**

Carter, Malkowski, Morrow, Sutherland, Wessenger, Winninger.

**The Chair:** Thank you. We'll now proceed to a government motion on subsection 10(6).

Mr Wessenger moves that subsection 10(6) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "who has been found incapable" in the second line.

**Mr Wessenger:** I think it's being deleted because it didn't make any sense when the person is unconscious; that's right.

**Mr Jim Wilson:** That line of reasoning has never stopped the government before.

**Mrs Sullivan:** Did the parliamentary assistant change the numbering as well, or is that done automatically? The numbering would, I think, become subsections (1), (2) and (3). Is that done automatically?

**The Chair:** Renumbering will be done in the reprint.

**Mrs Sullivan:** We will support this.

**The Chair:** Thank you. Seeing no further discussion, all those in favour of the government motion on subsection 10(6)? Opposed?

Motion agreed to.

**The Chair:** Next, the Liberal motion on subsection 10(6).

**Mrs Sullivan:** Mr Chairman, as a result of the government motion and the question of renumbering, my motion is redundant, so I won't put it forward.

**The Chair:** Thank you. Next, a Liberal motion on subsections 10(7), (8), (9), (10), (11) and (12).

Mrs Sullivan moves that subsections 10(7), (8), (9), (10), (11) and (12) of the bill be struck out, and the following substituted:

"(7) If a person who has been found incapable with respect to a treatment by a health practitioner indicates to the health practitioner a wish to make an application to the board under section 26, the health practitioner shall ensure that the treatment is not administered until,

"(a) seven days have elapsed since the person indicated the wish without an application being made to the board under section 26; or



“(b) the board gives a decision in the matter and,

“(i) the appeal period elapses without an appeal being commenced, or

“(ii) an appeal of the board’s decision is finally disposed of.”

**Mrs Sullivan:** This amendment comes forward as the result of changes we’ve made to earlier sections, which will not require an automatic rights adviser involvement but in fact a notification that, where the patient wants to involve the rights adviser in the course of making an appeal, this would be the appropriate method of doing so and that the treatment cannot continue until after the board has made its decision.

**Mr Wessenger:** We’ll be opposing the section because, in effect, taken in total, I think it would really take away the rights advice from the individual.

**Mr Jim Wilson:** I would agree somewhat with the parliamentary assistant, Mr Wessenger. To achieve what I think Mrs Sullivan is trying to achieve with this amendment, I don’t think it’s necessary to gut all the other safeguards and procedures in this section. On those bases, unless convinced otherwise, I’ll be opposing this amendment.

**The Chair:** Further discussion? Seeing no further discussion, all those in favour of the Liberal motion on subsections 10(7), 10(8), 10(9), 10(10), 10(11) and 10(12)? Opposed?

Motion negatived.

1800

**The Chair:** Now we’ll proceed to the PC motion on subsection 10(11).

Mr Jim Wilson moves that subsection 10(11) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out the portion before clause (a) and substituting the following:

“Treatment if rights adviser notified

“(11) If a rights adviser is required to be notified under this section, the treatment shall not be administered until.”

**Mr Jim Wilson:** As members know, the current subsection 10(11) requires a health practitioner who has made a determination of incapacity in circumstances set out in subsection 10(2) or subsection 10(3) to ensure that treatment is not administered until the criteria set out in subsection 10(11) are satisfied.

We feel it may be inappropriate where the health practitioner is no longer involved in the patient’s care to require such practitioner to be responsible for the supervision of potential treatment given by other practitioners. In other words, we’re worried that with the current wording as proposed by the government, there’s quite a liability to ensure notification of the rights adviser by sort of the first practitioner who may make the determination of capacity or incapacity, and that other people may be involved. In fact we had one witness, I recall, bring us through a situation in an emergency room where some 34 individuals were involved with treating a particular patient.

I think members understand the gist of this amendment, and there’s a following amendment to bring the bill in line with that reasoning.

**Mr Wessenger:** We’ll be opposing the motion, because it would appear to me that the effect of it is to take away the obligation right now on the health practitioner who is proposing the treatment and extend it right along to all the practitioners who deal with the matter. This way it clearly puts the onus on the practitioner who deals with the patient and proposes the treatment.

**Mr Jim Wilson:** That’s quite a responsibility to put on the, for lack of better wording, sort of first practitioner who proposes the initial treatment. Other teams get involved here, and a lot of other people get involved. Is it not feasible that the practitioner who proposes the treatment may not even be around when that treatment takes place, and therefore has the liability to ensure notification of the rights adviser but may not be there to do it?

**Mr Wessenger:** Perhaps I could just ask legal counsel to clarify, because I asked the same question concerning the matter in the sense that I wanted to be assured that if the health practitioner who ordered and proposed the treatment, once he had given the instructions properly, would not be held liable for some deviation from that. Counsel, I think, indicated that was the case. Perhaps counsel could just clarify that for you, because I asked the same question.

**Mr Sharpe:** Okay. The provision in the bill, of course, indicates that as a continuum, the health practitioner who is required to ensure that the rights advice be provided—and there are some amendments dealing with the form in which that’s done—shall also ensure that the treatment not be administered. The thought here is that it’s a continuum of responsibility. This is the person who set out the treatment plan.

It’s true that a technician in a part of the hospital where they’re conducting some kind of procedure not requiring that the doctor be there will not really know whether or not proper rights advice has been given; they’re there just to do the procedure. But it’s the doctor who has proposed the treatment who should follow through, contact the technician and let him or her know that the person has asked to meet with a rights adviser.

In other words, how would some technician necessarily know whether or not he or she is giving the treatment in defiance of the request by a patient to meet with a rights adviser? The doctor would know that, because he or she is the one who provided the rights advice and then received the response from the patient perhaps saying: “No, I don’t want to proceed. I want to talk to a rights adviser to discuss your finding that I’m not capable of making my own choices on this.” The technician might have no way of knowing that this discussion had taken place, and under the proposed amendment might then become liable for administering the treatment without knowing whether or not the person has asked for a rights adviser.

**Mr Jim Wilson:** It just seemed to us that it was a question of fairness. I understand your continuum argument, but it just seems to be another burden to place upon the health care practitioner proposing the treatment. I can

see it's problematic in terms of, where else do you put the responsibility?

I just have a question in this area. Do we assume, then, that the fact that the person has asked to see a rights adviser is clearly indicated on the chart or the records, and don't the records usually go with the patient down to X-ray or down to whatever team he or she sees next?

**The Chair:** Please respond.

**Mr Sharpe:** If the physician's in the hospital, on staff, and the patient is a hospital patient. But what if the physician's in private practice and has referred the patient into the hospital and it's in his or her own chart in the office? The technician in the hospital or in some private radiology clinic, for example, might or might not have knowledge that a rights adviser is involved. All the patient has is a requisition form. He is with a family member and they're taking the form to some clinic or to the hospital radiology wing, but the fact that he has told the physician that he wants a rights adviser may get lost in the process. So this is just keeping the responsibility on the initial provider who is proposing the treatment and giving the rights advice.

**Mrs Sullivan:** Isn't that very point the intent of the Conservative amendment, which would say that the practitioner, rather than ensuring that treatment isn't provided, which puts an additional obligation on the practitioner, perhaps should make his best efforts to ensure the treatment's not given? Given the multiplicity of health care providers in association with the care, say, of a complicated case, the obligation on the practitioner to ensure that the treatment doesn't take place at all, in any place, by any other practitioner until the rights adviser gets back to the original person with information, I just think imposes an enormous liability on the first practitioner, who may be the family doc. I wonder if the government would consider a little redraft there if Mr Wilson's wording doesn't quite work. I think something else has to work.

**Mr Jim Wilson:** I appreciate Mrs Sullivan's support. It just seems to me that in a real-life situation, it is almost impossible to put this much responsibility on the first practitioner, and we heard that in testimony. So I would be interested in seeing whether there is any flexibility there on behalf of the government.

1810

**Mr Wessenger:** I think we might be able to make a quick amendment on this. We have some advice from counsel with respect to an amendment that might satisfy Mr Wilson. It reads:

"(11) A health practitioner who is required to ensure that a rights adviser be notified shall take reasonable steps to ensure that the treatment is not administered until."

**Mr Jim Wilson:** That's acceptable.

**The Chair:** Could we have that amendment in writing, please?

**Mr Wessenger:** Doug will do it for us. Could we stand it down until legislative counsel has—

**The Chair:** Stand this down until we get it redrafted? Agreed? Agreed.

**Mr Jim Wilson:** Mr Chairman, I think subsections 10(10) and 10(12) might have to be looked at also. Let me just review that.

**Mr Wessenger:** We can do the same thing.

**Mr Jim Wilson:** Subsections 10(10) and 10(12) also?

**Mr Wessenger:** Yes.

**The Chair:** Maybe we could get it redrafted before you introduce it.

**Mr Jim Wilson:** That would be rather a common-sense way to go about things, wouldn't it?

**The Chair:** Thank you, Mr Wilson. You're so accommodating today. It's a pleasure to do business with you.

**Mr Jim Wilson:** It's all under protest, of course, you understand. It's taking a lot of bad things and trying to shine some light on them.

**The Chair:** Okay. Maybe we could proceed to the Liberal motion on subsection 10(14).

**Mrs Sullivan:** I think there are some other motions before that.

**Mr Jim Wilson:** They're going to look at subsection 10(12), I think.

**Mrs Sullivan:** All of subsection 10(12), including clause 10(12)(c)?

**Mr Jim Wilson:** Clause 10(11)(c).

**Mr Wessenger:** I think we can stand that down.

**Mrs Sullivan:** Oh, I wanted to vote for that one.

**Mr Jim Wilson:** I like it too.

**Mr Wessenger:** There's just some language that evidently has to be tidied up by legislative counsel.

**Mrs Sullivan:** Clause 10(11)(c).

**Mr Wessenger:** We have your clause 10(12)(a). We can do clause 10(12)(a)?

**Mrs Sullivan:** They're the same.

**The Chair:** Mr Wessenger moves that clause 10(12)(a) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "seven days" in the first line and substituting "forty-eight hours."

That's government motion on clause 10(12)(a) moved by Mr Wessenger. Comments?

**Mr Wessenger:** I would suggest that this makes the process much speedier, and I think all members of the committee hopefully can support this amendment.

**Mrs Sullivan:** We support this amendment, and I believe the similar amendment that's proposed for clause 10(11)(c) can also go ahead because the redrafting of the other section doesn't affect this particular subsection.

**Mr Jim Wilson:** On behalf of my caucus, I will be supporting this amendment and the clause 10(11)(c) amendment.

**The Chair:** Further comments? We'll proceed to the vote on the government motion on clause 10(12)(a). All those in favour? Opposed?

Motion agreed to.



**The Chair:** Mr Wessenger moves that clause 10(11)(c) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "seven days" in the first line and substituting "forty-eight hours."

Discussion? Seeing none, we'll proceed to the vote. All those in favour of the government motion on clause 10(11)(c)? Opposed?

Motion agreed to.

**The Chair:** The government reprint on subsection 11(2). No, sorry. The Liberal motion on subsection 10(14).

Mrs Sullivan moves that section 10 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"(14) Nothing in this section affects the law with respect to rights advice under the Mental Health Act."

**Mrs Sullivan:** This section was included in relationship to the very issues that we were discussing earlier about where and how rights advice is provided under the Mental Health Act, to simplify this act in terms of the two facilities, or the facility and the other than facility, and to ensure that the Mental Health Act isn't substantially changed from what has been not only the law but the practice.

I think that, given the standing down of previous amendments with respect to subsection 10(4), where we're in fact discussing the precise issue, I'll stand this one down too for consideration with that one.

**The Chair:** Do we have unanimous consent to stand this one down? Agreed.

**Mr Wessenger:** With respect to the Liberal motion, we'll be opposing it now. We have two further amendments which we will be submitting, assuming the Liberal motion is defeated, taking out the words "or prescribed health facility" and striking out "objects to the treatment or." I just thought I'd indicate what our intentions were.

**The Chair:** Excuse me, Mr Wessenger. You've lost me. What motion are we discussing here?

**Mr Wessenger:** The Liberal motion to subsection 10(4) is before the committee, as I understand it, and I just wanted to indicate at this time—

**The Chair:** You mean the 10(4) that was stood down?

**Mr Wessenger:** Yes, it was stood down; that's right. I thought we should go back to 10(4), which was stood down.

**Mr Winner:** Come on, Paul. I thought we were on 11(2).

**Mr Wessenger:** No, we're not to 11 yet.

**The Chair:** We go back to the Liberal replacement motion on subsection 10(4).

**Mr Wessenger:** What I thought I would indicate is that the amendments that we will be moving with respect to subsection 10(4), assuming the Liberal motion is not passed, are the deletion of "or prescribed health facility" and the deletion of the term "objects to the treatment or."

**Mrs Sullivan:** I have neither of those things in my motion.

**The Chair:** I can't find it in there either.

**Mr Wessenger:** No, they're not in the motion. Perhaps I should indicate that the purpose of our amendments is to preserve, in paragraph 10(4)(a), "the finding is made in a psychiatric facility."

**Mrs Sullivan:** I thought we stood it down so it could be printed up.

**Interjection:** Yes, we amended it.

**Mrs Sullivan:** So let's stand it down again.

Interjections.

**Mrs Sullivan:** We need it printed.

**The Chair:** Quite appropriately, right now, I think this would the time to have a recess, to go and have our meal, and then come back and sort this out. This committee will stand recessed for 15 minutes.

The committee recessed at 1820.

1907

**The Chair:** I call this meeting back to order. I believe we'll be going back to the Liberal replacement motion on subsection 10(4) that was moved by Mrs Sullivan. Mr Wessenger.

**Mr Wessenger:** Yes, we're going back to the amendment to subsection 10(4). We will be opposing this amendment.

**Ms Zanana L. Akande (St Andrew-St Patrick):** Which one is this?

**The Chair:** It's the Liberal replacement motion on subsection 10(4) that was moved by Mrs Sullivan, notice to rights adviser. Any discussion?

**Mr Jim Wilson:** The government has indicated it's opposing Mrs Sullivan's motion. We're voting on that?

**The Chair:** It's my understanding they're opposing this motion that was stood down in favour of another motion they wish to introduce. Discussion? Seeing no discussion, we'll proceed to the vote. All those in favour of the Liberal motion on subsection 10(4)? Opposed?

Motion negated.

**The Chair:** We'll move on to the government motion on clause 10(4)(a).

Mr Wessenger moves that clause 10(4)(a) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "or prescribed health facility" in the second line.

Motion agreed to.

**The Chair:** Next on a government motion on clause 10(4)(b).

Mr Wessenger moves that clause 10(4)(b) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "objects to the treatment or" in the eighth line.

Motion agreed to.

**Mr Wessenger:** I believe we're waiting for some amendments that are being photocopied by the clerk in respect to subsections 10(11) and 10(12).

**Mr Mark Morrow (Wentworth East):** Mr Chair, while we're waiting for that, why don't we move to subsection 11(2)?

**Mr Wessinger:** Is there any problem with that? No? We could move to 11(2).

**The Chair:** One moment, please. I believe we're on a Liberal amendment on subsection 10(14).

**Mr Wessinger:** That was stood down, if I remember.

**The Chair:** Was that stood down?

**Mrs Sullivan:** I think that's been dealt with as a result of the last series of amendments. If I did read it into the record, I withdraw it.

**The Chair:** Thank you.

**Mr Wessinger:** We can do 10(11) and 10(12) then. I have them back now. So we'll go back to 10(11) and (12).

**The Chair:** On the PC motion?

**Mr Wessinger:** No, on a government motion, 10(11) and (12). Then we can ask the PCs to move 10(11) and (12), if they want to do it.

**The Chair:** Okay. It's my understanding that we have new motions to replace these. Is that correct, Mr Wessinger?

**Mr Wessinger:** Correct.

**The Chair:** We have new motions to replace the PC motions 10(11) and 10(12)?

**Mr Wessinger:** Yes, I believe the PC might have to remove these.

**Mr Jim Wilson:** Do you want to see the new motions?

**The Chair:** We'll let them stand. All right.

**Mr Wessinger:** Until they move their motion, I think that's fair enough.

**The Chair:** Okay. We'll go to a government motion on 10(11).

Mr Wessinger moves that subsection 10(11) of the bill, as reprinted to show the amendments proposed by the minister, be amended by inserting after "shall" on the third line "take reasonable steps to."

**Mrs Sullivan:** Agreed.

**Mr Wessinger:** Agreed.

**The Chair:** Wait. Mr Wilson just received them.

**Mr Jim Wilson:** I certainly agree with this amendment and commend the government for showing some flexibility in this section.

**Mr Winninger:** Mr Chair, I wonder if we could get the amendment before the vote's called.

**The Chair:** Oh. My apologies. Has everybody received the government motion on subsection 10(11)? Shall we proceed to the vote? Agreed?

Motion agreed to.

**The Chair:** Mr Wessinger moves that subsection 10(12) of the bill, as reprinted to show the amendments proposed by the minister, be amended by inserting after "shall" in the seventh line "take reasonable steps to."

Discussion? Agreed?

Motion agreed to.

**Mr Jim Wilson:** Mr Chairman, would it be prudent to officially withdraw my amendments?

**The Chair:** You'll withdraw the PC motion on subsection 10(11) and subsection 10(12)? Thank you, Mr Wilson.

**Mr Wessinger:** I wonder if we might have unanimous consent, as we did earlier, to a deletion in 10(4)(b)? We found another "or prescribed health facility," and I ask that it be deleted. Unanimously carried? Good.

**The Chair:** Just one further question of the committee. On the Liberal amendment on 10(2), (3), (4) and (5), the alternate 2a, do we have anything on that? Was that reworked?

**Mrs Sullivan:** It passed, didn't it?

**The Chair:** No, that was stood down.

**Mr Morrow:** On a point of clarification, Mr Chair: Which motion are you referring to?

**The Chair:** Liberal amendment 10(2), (3), (4) and (5), and it was alternate 2a. I have it indicated that it was stood down. Has that one been reworked?

**Mrs Sullivan:** I like it the way it is.

**The Chair:** Okay, thank you. We'll carry on, then. Next we'll proceed to the government motion on subsection 11(2).

Mr Wessinger moves that subsection 11(2) of the bill, as reprinted to show the amendments proposed by the minister, be struck out.

**Mr Wessinger:** The reason for this is that the mandatory notice to the public guardian and trustee about long-term incapacity no longer serves its former purpose. Bill 108 has been amended to reduce the need for a court-appointed guardianship by providing for a diminished-capacity power of attorney for personal care and allowing for attorneys to act without requiring validation in all cases.

Motion agreed to.

**Mrs Sullivan:** Mr Chair, my motion is precisely the same as that which the government has just put forward.

## 1920

**The Chair:** On the government reprint 11(3). Discussion? No discussion. Proceed to the vote. All those in favour? Carried.

Next is a Liberal motion on section 12.

Mrs Sullivan moves that section 12 of the bill, as reprinted to show the amendments proposed by the minister, be amended by inserting after "been" in the seventh line "registered or".

**Mrs Sullivan:** This amendment brings this section into line with changes made to Bill 108.

**Mr Wessinger:** I'm going to ask staff to comment on this one.

**Ms Auksi:** I think there was some misunderstanding with some of the groups as to the significance of saying "registered" as opposed to having expedited validation.



In Bill 108 there's a new procedure allowed for getting a power of attorney to take effect without all the usual safeguards and I guess that's called the expedited validation process, the so-called Ulysses contract type of quick coming into effect of a power of attorney, where people had said in advance, for example, that they wanted to be admitted to hospital when incapable, even if objecting.

The thing is that the expedited validation is still covered off by the term "validated power of attorney." If one merely says a registered power of attorney, the step that is missed that's essential is the assessment of capacity. The expedited validation only requires one assessment, as opposed to two assessments for the usual validation process. So it's already a kind of shorter version of coming into effect.

If one didn't require any assessment at all and if one had just simply registered that one wanted this to happen, there would be no way to say with due rights protections that this person had been found incapable and that there was now no question about it. Have I answered your concern?

**Mrs Sullivan:** No, because in fact 11(1) tells us that the health practitioner has just found the person incapable.

**Ms Auksi:** Yes. The problem with a finding of incapacity by the health practitioner is that it's by someone who isn't necessarily expert in a finding of incapacity. We have to acknowledge that while people may in some cases be expert, many will not be and that's the reason for allowing there to be a review.

The assessors under the Substitute Decisions Act, on the other hand, are people who will be specially designated and trained in some way and will have a certain expertise that not every health practitioner will have. So the right of review is not an every instance thing. It's a right of review if you make an application, but it's something that's up to the individual to decide whether to exercise or not.

**Mrs Sullivan:** I put it to you that if the health practitioner who is required in virtually every other section of this act with respect to incapable people is himself or herself incapable of making an assessment, this act is meaningless.

**Mr Wessinger:** We'll be opposing this amendment for the reason that sections 10 and 11 should not be excluded except in those circumstances where there is either a guardian appointed or a validated power of attorney. Of course, it's been indicated that there are two ways a power of attorney can be validated: one, with the longer process or, two, the situation where an attorney is registered and then an assessor determines that incapacity. If we accepted the amendment, in effect we would have the rights advice being completely overridden just by the simple fact of a person executing a power of attorney.

**Mrs Sullivan:** The execution of the power of attorney is an indication of the wishes of the person while capable. That's the entire authority and concept of being able to give a power of attorney. One makes decisions while capable with respect to the person who will be able, under certain circumstances, to exercise certain decisions and the nature of the decisions that person will be able to execute.

This section says a health practitioner who finds that a person who is 16 years of age or more is incapable may notify the public guardian and trustee of that fact and give notice to the person, but this requirement of the practitioner doesn't apply if the person has a guardian or a power of attorney for personal care. The person, himself or herself, has already determined what and who are in the power of attorney. If the person has in fact executed a power of attorney and that power of attorney has been registered, why is it also necessary for a health practitioner to advise the PGT of that process? The person, himself or herself, has made the decision.

Again, this is a lot of bureaucratic silliness and an extra obligation on the health care practitioner that isn't necessary when the person either has a guardian because that person has no one else, or has made a decision about whom he or she will have.

**Mr Wessinger:** I will respond, and perhaps Mr Winninger may want to make some comments on this with respect to his legislation as well.

**Mrs Sullivan:** He agrees with me.

**Mr Winninger:** No, quite the contrary.

**Mr Wessinger:** The fact that a person makes a power of attorney when competent, setting out certain requirements of when the power of attorney may come into effect, to say that power of attorney can come into effect contrary to the provisions of that power of attorney seems somewhat strange to me. The power of attorney could say, for instance, that if it is determined that I am found incapable by psychiatrist X or psychologist X—I don't know; Mr Winninger is more familiar with the act—that would be the determination. In fact, there has to be an assessment under the act to determine if a person is incapable. To give the authority to any health practitioner to make the decision that a person is incapable with no right of appeal defeats the whole purpose of the provision of rights.

I don't know what would be the situation in the event that the power of attorney provided that a particular health practitioner could make an assessment, who had the capacity—shall we say a psychiatrist. Could that health practitioner have both roles, for instance, of being assessor and practitioner in the circumstance? Mr Winninger should comment on this.

**Mr Winninger:** I don't know that I can add any clarity to what Mr Wessinger has already said. I would be particularly concerned if we short-circuited the process and excluded rights advice under validation.

**Mrs Sullivan:** Are you talking about the same amendment I am talking about?

**Mr Winninger:** Quite frankly, I was having some difficulty following a lot of your statements in the last five minutes. I'm looking at an amendment to section 12. You want to add the words "registered or." Mr Wessinger has pointed out quite correctly that if you allow "registered" to go in, you could bypass the provision of rights advice to the vulnerable individual. That concerns me. The inclusion of the word "validated" is certainly sufficient to encompass the situations that section 12 contemplates. I'm not sure how "registered or" will add anything to that section,



but it will certainly preclude rights advice in certain situations, which is certainly not the intent of our bill.

1930

**Mrs Sullivan:** It reflects the capable will of the person involved.

**Mr Winninger:** If I may, Mr Chair, the person involved executes a power of attorney for personal caring, saying, "If I become incapable, I wish so-and-so to make my personal care decisions for me." That's one point in time. Down the road at another point in time, there has to be a determination whether that person's incapable or not. That's where the assessor comes in, and prior to the assessment, the rights advice comes in.

If you just say that, upon registration, the power of attorney automatically takes effect, you are dispensing with a lot of safeguards we felt it was prudent to include, because decisions can be made on behalf of a vulnerable individual that could be extremely intrusive on that person's autonomy.

If I'm misreading what you're suggesting, let me know, but I think I do understand the implications of your amendment. Quite frankly, I don't find it that appealing.

**Mr Jim Wilson:** I think where the honourable members are at loggerheads is in coming at this from a couple of different directions.

The way I understand Mrs Sullivan's argument makes sense in the context that someone has drawn up a power of attorney and registered it. They are, in essence, waiving their right to rights advice, because they were fully cognizant of that when having the power of attorney drawn up—I assume that is what Mrs Sullivan would assume—knowing that at some point they would be assessed as to their capacity; and because they know what's in their power of attorney, they don't need any more rights advice. I think that's the point.

**Mrs Sullivan:** They've made the decision.

**Mr Jim Wilson:** Whereas the government seems to want to ensure there's an extra safeguard there in terms of rights advice. I just think of my own life in drawing up a power of attorney. The whole purpose of doing it would be so that I would have the ability, while I was capable, to express how I want to be treated when I'm deemed incapable. I probably wouldn't need rights advice.

The government wants to consider the amendment in light of the fact that it may save resources. Why revisit people who have already taken decisions?

**The Chair:** Further comments?

**Mr Winninger:** I should just add, upon looking again at the actual text of section 50 of Bill 108, that it's not just rights advice; it's advocacy.

**Mr Jim Wilson:** Yes. So how do you get these people out of your life? You draw up a power of attorney. Yet you people say, on behalf of the state, "They've got to come in anyway." So why do you go through all this when you're capable?

**Mr Winninger:** To provide the appropriate safeguards, to ensure that when you're taking away—

**Mr Jim Wilson:** Maybe people don't want your safeguards because they don't see the world the way you see the world. I certainly don't want them. Society's functioned quite well, with a few exceptions, and it's the exceptions that this act should deal with.

**Mr Winninger:** We see the world differently. I agree on that. That's why you're there and I'm here.

**Mr Jim Wilson:** It's hard to argue that one, except that they didn't know you saw the world the way you see it when they voted.

**Mr Morrow:** Yes, they did.

**The Chair:** Further comments? Seeing no further comments, we'll proceed to the vote. All those in favour of the Liberal motion on section 12? All those opposed?

Motion negatived.

**The Chair:** PC motion on subsection 13(2.1).

Mr Jim Wilson moves that section 13 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Unwritten wishes

"(2.1) Wishes that are not expressed in written form shall have effect only if they are expressed directly to,

"(a) the person authorized to give or refuse consent to the treatment; or

"(b) the health practitioner who proposes treatment."

**Mr Jim Wilson:** We think this is a very commonsense approach in dealing with this. I remind members that this amendment's been recommended by the Ontario Medical Association, the Ontario Nursing Home Association, the Ontario College of Nurses, the Alzheimer Association of Ontario, the College of Physicians and Surgeons, the Ontario Friends of Schizophrenics and the Registered Nurses' Association of Ontario. During the dinner break that's all I was able to dig up, but I'm sure there's more support out there.

It is self-explanatory, and I think it ensures that there's a direct communication of these unwritten wishes and that it tries to foresee the fact that there may be confusion out there, and we're trying to limit the confusion as best we can.

**Mr Wessenger:** We'll be opposing this motion. I might perhaps give the example of where it would be an unfortunate amendment in the sense that there could be instructions given by a brother to another brother, and that brother then communicates those instructions to the spouse. The spouse would not be listened to because the spouse had not directly heard the wishes. It would exclude fairly good and direct evidence with respect to the expressed wishes of an individual, and we don't want to restrict that.

**Mr Jim Wilson:** How can you be sure though, under that scenario, that—the more people involved, the less likelihood of the accuracy of the expressed wishes of the individual, I would think. You've played that game where you go around the room and start with one sentence and see how it turns out after it's gone around a few times.

**Mr Wessenger:** If I might just respond, I think in practicality it's going to be the substitute who is probably



giving the evidence, but certainly the substitute should be able to rely on information that the substitute himself or herself considers reliable. The practicality of it is that if the substitute didn't think the wishes were valid, he or she wouldn't communicate them. It's going to be the substitute expressing them, if I'm correct.

**Mrs Sullivan:** I think what this amendment is driving at is the authenticity of wishes around which there's no proof that the wishes were given. The third-person wish, which may not reflect the wish of the individual, or the third person expressing the wish, as he or she understood it, to the substitute decision-maker, in fact isn't the line of authority for the substitute decision-maker who is authorized in the substitute hierarchy to take account of.

The person who is authorized to give or refuse consent in fact has an obligation, as we know, to act if he knows of a wish that the person has expressed, and if he doesn't know of a wish the person expressed, to act in the person's best interests. A third or fourth party coming to the substitute decision-maker with an expression of a wish as information, in my view, should never be taken as direction by the substitute decision-maker.

I'll be supporting this amendment. I think it's reasonable. I think it provides a responsibility on the substitute decision-maker to know and understand and convey the wishes of the person for whom he's making a substitute decision. It conveys an authority and a responsibility on the health practitioner, to whom in fact many people convey their wishes and intentions, to act on direct information that comes from that person who is affected. If there is no wish they have knowledge of, then they are entitled to act in the person's best interests. I think this is a useful amendment and an appropriate one.

1940

**Mr Jim Wilson:** I'm just wondering, in terms of the liability here, if you're getting third- and fourth-hand wishes, as it were, first of all, the health practitioner has to act on those wishes. I think it puts them in a rather precarious position.

Secondly, if you got a substitute decision-maker when you were capable, set up a power of attorney, did a number of other things the legislation allows you to do—if, for instance, you made those arrangements. Even if you didn't, in both cases—the second case being you would assume that the substitute decision-maker was someone close to the individual—I would think you would not tell your brother, who you know is not your substitute decision-maker. You would tell your spouse your most recent wishes and therefore we'd have your most recent wishes, not the brother who comes in from Calgary—you live in Toronto—and he says, "Three months ago Jim said this to me and I really believe that's his most recent wish or strongest wish, or whatever," I would think that if the spouse concurred with that, you would find the spouse saying, "Yes, I think that is my husband's strongest or most recent wish," and therefore would conform to this amendment.

I think it's better to err on the side of getting the most accurate wish possible rather than this chain of wishes that

may or may not reflect the individual's wish. I would want that. I come from a large family. Goodness knows how many opinions you're going to get on my most recent wishes, and I talk to them, being their member, every day. Unless they write down what hour I've talked to some of these people, I'm sure in my dying moments—because I'm a bit like the Prime Minister in that I love to use the telephone—they're going to have to compare notes. It should be the person closest who is going to be, I would think, the substitute decision-maker, the spouse. It gets the health practitioner out of a rather precarious situation, I would think.

**Mr Morrow:** You did, didn't you? I thought you said you were like the Prime Minister.

**Mr Jim Wilson:** I was just trying to—

**Mr Wessinger:** First of all, with respect to the substitute giving instructions to the health practitioner, there is section 25, which provides that a person who gives or refuses consent to treatment on another person's behalf acting in good faith is not liable. The only test is good faith with respect to the substitute who makes the decision, so the substitute is really going to determine how to interpret the wishes of the individual, and as long as he or she acts in good faith, there's no liability on the substitute. In addition, there is the provision with respect to the health practitioner, the override provision with respect to wishes, where they don't believe they're reliable.

Again, I believe they're excused from liability in the case of good faith or—what is it in that one?—unreasonable grounds. That's right, there's an inclusion on the health practitioner on reasonable grounds.

**Mr Jim Wilson:** I understand all that. I read the act too, more than once. This attempts to narrow it down. I don't know why you wouldn't want to be a little more specific when the people who have to make this act work, all those organizations, very much want this type of safeguard. I just find it mind-boggling that you wouldn't agree to this amendment.

**Mr Winniger:** I don't want to muddy the waters here, but let's say there was a situation where a parent was in extremis and the son and daughter attend upon the health care practitioner. The daughter may believe in euthanasia and declares her parent told her that he wanted all life support systems to be withdrawn, yet the son says precisely the opposite, that his parent told him that he wanted them kept on. What's a health care practitioner in a situation like that going to do? I'm looking for some clarification from Mr Wessinger on that.

**Mr Wessinger:** I'm just getting advice from legal counsel here. I think for clarity's purpose, there's no obligation on the health practitioner to follow the wishes. The obligation is to follow the instructions of the substitute. It's the substitute's obligation to determine the wishes, not the health practitioner's.

**Mr Jim Wilson:** My expression of that was not clear. I understand that. We're just trying to make sure that the person determining the wishes and then communicating them to the health care practitioner knows clearly what the wishes are.

**The Chair:** Further discussion? Seeing none, we'll proceed to the vote. All those in favour of the PC motion on subsection 13(2.1)? Opposed?

Motion negatived.

**The Chair:** I would remind all members that they are obliged to vote.

**Mr Jim Wilson:** I will withdraw the next amendment, given that it pertains to the amendment that was just defeated.

**The Chair:** That's subsection 14(1)?

**Mr Jim Wilson:** That's 14.1.

**The Chair:** Thank you.

The government reprint 14(1).

**Mr Wessenger:** No, I was going to ask that this be stood down.

**The Chair:** Do we have unanimous consent to stand down—

**Mr Jim Wilson:** No.

**The Chair:** We don't have unanimous consent.

**Mr Jim Wilson:** I'd like to ask a question on this. If we agree to stand this down, will we see it back, Mr Wessenger? I happen to know the views of the NDP on this, and I have the feeling it's one of these that may just slip in and we won't have an opportunity to discuss it if it doesn't come back. Has it been introduced, and you're standing it down?

**The Chair:** It's deemed to be moved, as it's in the reprint now.

**Mr Wessenger:** Perhaps I can assure the member that hopefully—I assume we'll be back tomorrow morning, but—

**The Chair:** Would you like to put a time limit on this?

**Mr Jim Wilson:** We've heard this before.

**The Chair:** Have it stood down till first thing tomorrow morning?

**Mr Jim Wilson:** Well, if they'd agree with that.

**Mr Wessenger:** No, that's not—

**Mr Jim Wilson:** Because I know what they're up to, Mr Chair. It's the usual technique. I think Elie Martel invented it.

**Mrs Sullivan:** Mr Chairman, I'd like an explanation from the parliamentary assistant on why the government wants to stand down 14(1) of the bill, which speaks about the principles behind a substitute decision-maker providing consent, and what options it is looking at to replace it or what other issues or areas it wants to add.

**Mr Jim Wilson:** It's 14.1. It's their amendment, Barbara.

**The Chair:** No, we're on 14(1).

**Mr Wessenger:** Yes.

**Mrs Sullivan:** Yes, 14(1); it's in the reprint.

**Mr Jim Wilson:** Well, then, I withdraw everything I just said.

**Mr Wessenger:** It's a new motion.

**Mr Jim Wilson:** I thought you were dealing with—

**The Chair:** No, we're on the government reprint.

**Mr Wessenger:** Oh, excuse me. No, we're not standing down subsection 14(1), not at all. I'm sorry.

**The Chair:** Subsection 14(1).

**Mr Wessenger:** Sorry about that.

**The Chair:** My apologies. This is where I am right at the moment.

**Mr Jim Wilson:** I thought you were at 14.1.

**Mr Wessenger:** No, 14.1 is the one—

**The Chair:** No, we're in the government reprint.

**Mr Wessenger:** Yes, still the government reprint. My apologies.

**Mr Jim Wilson:** My apologies. I really thought you were pulling a fast one.

**The Chair:** We're at subsection 14(1) in the government reprint. Any discussion on the government reprint? Agreed? Carried.

Okay, we're on the government motion on section 14.1.

**Mr Wessenger:** Yes, if I might ask, I'm going to have that withdrawn.

1950

**The Chair:** Withdrawn?

**Mr Wessenger:** Yes.

**The Chair:** It's not necessary, but thank you. The Liberal motion on section 15.2.

Mrs Sullivan moves that the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following section:

"Child in need of protection

"15.2 Nothing in this act affects the law with respect to a child in need of protection within the meaning of subsection 37(2) of the Child and Family Services Act."

**Mrs Sullivan:** This amendment is self-evident. As you know, we had significant representations made before the committee from children's aid societies and others who were concerned about the effect of this act on the responsibilities and indeed the duties accorded to children's aid societies under the Child and Family Services Act. We heard at one point in the hearings from a representative of the Ministry of Community and Social Services. It was clear that they were uneasy with some of the balances between the responsibilities under this act and the responsibilities under the CFSA.

In my view, Bill 110 goes some distance in bringing those issues together, but I don't think it goes far enough, and this amendment is to ensure that there is no misunderstanding or indeed no authority taken away from children's aid societies to operate according to their statutory duty.

**Mr Wessenger:** I'd ask that this be stood down. The reason is, I think there is some concern about the language from a legal point of view, and we'd like further time to have counsel look at it.

**Mrs Sullivan:** We've had experience with the government party with reference to standing motions down. I believe we got about 50% of the way through Bill 74 in



terms of discussion, and about 50% of the amendments that were put forward were stood down, we were told, for further discussion, for consultation between ministries; because the government hadn't got its act together was in fact the truth.

We don't believe the government wants to complete that bill. We are very concerned about standing down motions. If I can have an explanation of the rationale for standing this motion down, I would be interested in hearing it, but believe me, on Bill 74, when and if we get back to that one, we won't be standing down anything else, because we frankly don't trust their promise.

**Mr Wessenger:** I'm just wondering, I think there might be—

Interjections.

**The Chair:** Mr Wessenger has the floor, please.

**Mr Wessenger:** Perhaps we could have a short recess, should we, to see if we can discuss this clause? Three minutes maybe?

**Mr Jim Wilson:** The other thing is, you can stand it down if you give us the assurance of when it's coming back.

**Mr Wessenger:** It might come back tomorrow morning, I would suggest.

**Mr Jim Wilson:** Okay. We'll take you at your word that it'll be back either tonight or tomorrow morning at the latest.

**Mr Winninger:** Would you rather have it in writing?

**Mr Jim Wilson:** I'd like it in blood, but I won't go that far.

**Mr Wessenger:** We've only had three motions stood down so far, so this will only be four.

**Mr Jim Wilson:** Yes, we're all doing a good job, but the precedent's been set by your colleague.

**Mrs Sullivan:** And a request for a fourth.

**The Chair:** Do we have unanimous consent to stand this down to, at the very latest, first thing tomorrow morning? Agreed.

**Mr Jim Wilson:** What was that? Subsection 15(2)?

**The Chair:** It's section 15.2.

Government reprint, subsection 16(1). I believe it's just a deletion. Agreed? Carried.

Government reprint, subsections 16(2), (3) and (3.1).

**Mrs Sullivan:** Did we do 15?

**Interjection:** We stood it down.

**The Chair:** The government reprint? That's a whole section.

**Mrs Sullivan:** All right. Will we have an opportunity to have some discussion of those particular sections, even though they're entire sections?

**The Chair:** If you choose.

**Mrs Sullivan:** I'm asking about the process here. If the only way we can get this issue on the floor is to propose an amendment, then I think that perhaps is the way to go. If there can be a discussion of this area and a clarification

from the ministry about certain next steps, I'd appreciate that.

**The Chair:** When we're through all the amendments, we could go back and ask for further comments, and at that time we can discuss whole sections if the committee so chooses, or we can discuss it right now. I'm at your disposal.

**Mrs Sullivan:** I'd like to have, frankly, a little clarification of what the government's intentions are in terms of making the Weisstub report public, what consultative process it's going to bring forward to deal with the issues related to research and what the next steps will be in terms of codifying a new consent-to-treatment statute with respect to the research issues. Those issues are clearly of vital importance, not only to people who are currently suffering from disease and illness but to people in the future, for whom that disease and illness can be avoided when research is carried out.

We had proposals before the committee. We did not proceed with any amendments on this area because, frankly, we were promised the Weisstub report, and it wasn't forthcoming. I'd like to know what the next steps are.

**Mr Winninger:** On a point of order, Mr Chair: I don't believe that what Ms Sullivan is asking for now is relevant to the clause-by-clause in which we're engaged.

**The Chair:** There is a government reprint on sections 15 and 15.1. We've agreed not to close any sections off; we still are open for discussion on them. Mr Wessenger.

**Mr Wessenger:** I have no objection, for clarification purposes, to asking legal counsel to update the committee with respect to this matter.

**Mr Sharpe:** Professor Weisstub provided us with a few pages of his draft report dealing with age of consent, and of course it was included in the ministry opinion on the common law aspect. He did not provide us with anything substantive on research models that would enable some form of approval process to be put in place so that research protocols could proceed on sound legal footing. That is one of the main issues he's looking at, of course, research on populations which are not able to provide their own informed consent, and he's promised us the report this fall.

I know he's working on a draft and polishing and finishing it. I don't know when he's going to submit it, though. I would assume that once it's submitted it would be made public and there would be a consultation process with everyone, including the research community, to determine what their views were on his recommendations.

**Mrs Sullivan:** I don't think counsel should be answering this question, but perhaps the parliamentary assistant would. Is it the government's intention to proceed with separate consent to research procedures which codify processes, procedures and principles with respect to research on incapable people and involving incapable people?

2000

**Mr Wessenger:** I think that would be difficult to answer without having the report in and doing a consultation process. Obviously, if you could have the report in and could do a consultation process before you came to third reading of this bill, then it would be possible to incorporate an amendment. However, I would venture to say I am somewhat sceptical that is achievable at this stage since we don't have the report. It will likely have to be by separate legislation, but as I said, that's only assuming the process would not be completed in time.

**Mrs Sullivan:** I guess all the way through, I've been disappointed in this area. While there was a change made to this section, we certainly know the Alzheimer's patient who is in the advanced stage of the disease, the schizophrenic who is in a psychotic period, people who are in certain other stages of disease where research procedures don't create enormous suffering and in fact can benefit not only those individuals but a generation of people. All of those issues are matters of enormous concern, enormous spending of public dollars and a divergence of ethical stances from place to place in terms of the procedures.

I think we have not explored this adequately. I don't think the government's given enough attention to it. We've had some really quite extraordinary individuals before us who are involved in bioethics, medical-legal ethics and research practices themselves, and they too want to see some action here. Frankly, if we are going to be doing something that is important in terms of making strides in the research leading to a cure for certain diseases and illnesses, I think this is an area that could have been of some big help.

**Mr Jim Wilson:** While I appreciate a number of the concerns expressed by Mrs Sullivan, I certainly was satisfied with the government reprint and the government's change in this area. I have not received any feedback from the research community, of which my oldest brother is a prominent member, that it is in any way unhappy with the government reprint. Keeping that in mind, I remind the public that my phone number is 325-3858, and if I'm wrong, feel free to call at 9 o'clock tomorrow morning.

**The Chair:** Further discussion? Seeing no further discussion, we'll proceed along to the government reprint on subsections 16(2), (3) and (3.1). Discussion? Agreed? Carried.

Government reprint, subsection 16(5). Agreed? Carried.

Government reprint, subsection 16(5.1). Agreed? Carried.

Government reprint, subsection 16(7). Agreed? Carried.

Government reprint, subsections 16(10) and (11). Agreed? Carried.

Next is a Liberal motion on subsection 16(10.1).

Mrs Sullivan moves that section 16 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Form of statement

"(10.1) A statement under subsection (10) may be made in the prescribed form."

**Mrs Sullivan:** Subsection (10) of section 16, which is what we're dealing with here, requires that a person who is

giving consent on another person's behalf make a statement that could be lengthy. It talks about identifying his or her relationship with the incapable person, saying that he or she has no reason to believe that the incapable person, before becoming incapable, would have objected to his or her making the decision and so on.

Frankly, in the course of decision-making on behalf of another person, what is more important, it seems to me, to the substitute decision-maker is receiving the information and making the decision based on the same issues that the incapable person himself or herself would make that decision on: the risks, the treatment methods, the disease and illness, the proposals for recovery and change in the course of the health of the person.

Those are the important things around which the substitute decision-maker should be concentrating, not on filling out a whole bunch of pieces of paper in a lengthy manner. In my view, a prescribed form that contains the detail that a person can attest to is the appropriate way to go. It simplifies the whole thing.

**Mr Wessenger:** I find Ms Sullivan's arguments persuasive and we'll agree to this amendment.

**Mr Jim Wilson:** I was just going to add that I thought Mrs Sullivan's argument showed innovation and she deserves five stars for them. I'd certainly be happy to support this amendment, because it does simplify what is a very complicated part of this legislation, and she should be commended for that.

**The Chair:** Further discussion? Proceed to the vote. All those in favour?

Motion agreed to.

**The Chair:** Unanimous consent on the government reprint, section 17, deletion? Agreed.

We have a PC motion on subsection 19(1).

Mr Jim Wilson moves that subsection 19(1) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "subject to subsection (2)" in the last line.

**Mr Jim Wilson:** The rationale behind this amendment is that we believe a substitute decision-maker should have the authority to consent to an admission to a psychiatric facility, that it should not be limited to just the guardian or the attorney for personal care or a power of attorney.

We feel that the way the government reprint has come back, it inappropriately limits the treatment options available to the substitute decider and we're looking for a little broader scope in here.

**Mr Wessenger:** We'll be opposing this because it would take away the rights under the Mental Health Act.

**Mr Jim Wilson:** Perhaps you'd like to elaborate on that.

**Mr Wessenger:** I'll ask counsel to explain then.

**Mr Sharpe:** As I understand this motion and the next, it would delete subsection (2), which was put in there in order to deal with the patient who objects to being admitted to a psychiatric facility for treatment, and in that case the added safeguards would be that consent can only be given by a guardian under the Substitute Decisions Act and an attorney for personal care where that has been validated.



The concern here is that this could be used if subsection (2) were not there as a means of circumventing the committal procedures under the Mental Health Act for objecting individuals. This is apart from public health laws, where someone is in danger of communicating a virulent disease to someone else and we have the authority to go to a judge, on the request of a medical officer of health, to get an order to confine and treat the person. Mental health is the only area where society confers authority to deprive a person of his liberty because he is ill and a threat to society.

There is a procedure with protections for doing that under the Mental Health Act that have been debated a number of times in the Legislature. The concern was that while we're trying to regularize a procedure in subsection 19(1) to admit people for treatment, there seems to be a bit of a gap now where an individual comes to a hospital, is incompetent and is with a family member. There's nothing, for example, in the Public Hospitals Act that deals with whether the substitute has the ability to admit the person to the facility, so subsection 19(1) was aimed at facilitating that process. But at the same time, we had hoped not to open a side door around the committal protections of the Mental Health Act. That's why subsection 19(2), with the protections requiring a guardian or an attorney for personal care to make those decisions, was seen to be important.

2010

**Mr Jim Wilson:** The thrust, obviously, behind the amendment is to try and expand those safeguards to include a substitute decision-maker. As you know, a number of witnesses were not only concerned, but really felt very discouraged by the current provisions of the Mental Health Act, and felt powerless in terms of families dealing with a schizophrenic daughter or son. That's certainly the intent of the legislation: Was there any debate to broaden the scope of subsection 19(2) in terms of who else may make that decision?

**Mr Winninger:** I think section 19 as it's currently drafted is sufficiently broad that it would meet the concerns we heard expressed by such groups as Friends of Schizophrenics. They were concerned about the revolving-door syndrome, where a patient is admitted who meets the test under the Mental Health Act, then receives treatment, then is discharged from the hospital, and again, perhaps because he or she doesn't take medication or for whatever other reason, then acts out again or exhibits a mental disorder. Each time, either the substitute decision-maker would have to obtain an order from a justice of the peace to get that individual back in the mental health facility or the police would have to become involved or whatever the situation was.

The people who came before us seemed to take heart in knowing that a guardian could be appointed or that a power of attorney for personal care could be validated, which would effectively bring an end to that revolving-door syndrome. I think it's important that we do have validation or that we do have judicial consideration as to who should be the guardian. I don't think you can just dispense with those formalities and safeguards and allow any substitute decision-maker to admit to a psychiatric facility,

which will certainly deprive the individual of a number of civil and legal rights.

**Mr Jim Wilson:** My thoughts on this are that, although we heard the same testimony from parents of schizophrenics, for instance, I don't think they took heart from what the responses were on the government side. They felt that being forced to go through the judiciary was indeed a very onerous, time-consuming and complicated process and they did request of this committee that we consider expanding the decision-making authority and giving this power to the substitute decision-maker. Having said that, I understand the safeguards you're speaking about. With that, Mr Chairman, I suggest we vote on the amendment.

**The Chair:** Seeing no further discussion, we'll proceed to the vote on the PC motion on subsection 19(1). All those in favour? Opposed? I would remind all committee members that they are supposed to vote.

Motion negated.

**The Chair:** PC motion on subsection 19(2).

**Mr Jim Wilson:** I won't be introducing the motion, given that it refers to the amendment that was just defeated, Mr Chairman.

**The Chair:** Thank you. Are there any comments on government reprint 19.1?

**Interjection:** Carried.

**The Chair:** No, I just asked for discussion. Government motion on section 20.

Mr Wessinger moves that section 20 of the bill, as reprinted to show the amendments proposed by the minister, be amended by inserting after "shall" in the fifth line "take reasonable steps to."

**Mr Jim Wilson:** I certainly will be supporting this amendment, given that it stems from the earlier discussion we had about subsection 10(11), and I appreciate the government bringing forward the amendment at this time. Having said that, I won't be introducing the PC amendment pertaining to section 20.

**The Chair:** Thank you. Further discussion on the government motion on section 20? Agreed?

Motion agreed to.

**The Chair:** Okay. Would the committee agree to going to subsection 22(10)? This should solve some problems. We'll go to the government motion on subsection 22(10). Is that agreed? This will facilitate things when we get to subsections 22(1) and 22(2).

Mr Wessinger moves that section 22 of the bill, as reprinted to show the amendments proposed by the minister, be amended by adding the following subsection:

"Application of section 10

"(10) Section 10 does not apply to a treatment authorized by this section."

**Mr Wessinger:** The purpose of this amendment is to provide that rights advice does not apply in the situation of an emergency treatment.

**Mr Jim Wilson:** I certainly would agree with this amendment.

**The Chair:** Agreed?



Motion agreed to.

**Mr Jim Wilson:** For the record, Mr Chairman, that amendment was exactly the same as the next motion under subsection 22(10), the PC motion, and of course I won't be introducing that motion.

**The Chair:** Thank you. Okay, government amendment 22(1).

Mr Wessinger moves that subsection 22(1) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "section 4, subsections 10(11) and (12) and section 20" in the first and second lines and substituting "sections 4 and 20."

2020

**Mr Jim Wilson:** Given that it's identical to the PC motion dealing with subsection 22(1), we're supporting the government motion and not introducing subsection 22(1). I don't want the government to think that I'm somehow starting to be very agreeable because it's past 8 o'clock at night.

**The Chair:** I'm sure we will reach an impasse at some point. Thank you, Mr Wilson.

Further discussion? Seeing no further discussion, we'll proceed to the vote. All those in favour?

Motion agreed to.

**The Chair:** Mr Wessinger moves that subsection 22(2) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "Despite subsections 10(11) and (12)" in the first line.

**Mr Wessinger:** Again, there's a PC motion that parallels this one.

**Mr Jim Wilson:** I just want to know how you got all my good ideas. This is rather fishy. None the less, I certainly agree with the government amendment.

**Mr Wessinger:** Obviously, the instructions were the same to legislative counsel. I think that's fair to say.

**The Chair:** Further discussion? Agreed?

Motion agreed to.

**The Chair:** Mr Wilson, you will not be introducing your next motion?

**Mr Jim Wilson:** That's correct.

**The Chair:** Thank you. Could we go back to the government reprint of 22(1) and (2) as amended? Agreed? Carried.

Mrs Sullivan moves that subsection 22(3.1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Examination

"(3.1) Despite sections 4 and 20, a health practitioner who is of the opinion that a person is incapable with respect to a treatment may conduct an examination of the person and perform diagnostic procedures on the person, without consent, if the examination or procedures are reasonably necessary for the purpose of determining whether subsection (1), (2) or (3) applies to the treatment."

**Mrs Sullivan:** Mr Chairman, you know that earlier I put in two motions for amendments to subsection 1(1) respecting the recommendations that have been put forward

by the College of Physicians and Surgeons with respect to diagnostic evaluation. I think their recommendation is one that cannot but be accepted in one of these forms.

I think the use of the words "diagnostic procedures" rather than the more medical terminology of "diagnostic evaluation" is in fact a preferable approach, because it would provide the consumer as well as the physician with an understanding that the evaluation or the assessment isn't merely by look; it can also be by touch and by instrument. I think the use of "procedures" is useful in that way. As a consequence, my preference is 22(3.1) so that there will be an understanding that the procedure to establish a diagnosis is itself not subject to the consent requirements.

**Mr Wessinger:** I wonder if Mrs Sullivan might be prepared to accept some changes that are suggested by legislative counsel. These changes are in the third line. "And" is taken out and there are the words "including the performance of diagnostic procedures on the person." Then in the fifth line the word "or" is taken out and the word "and" is inserted. The reason for the "including the performance" is because we want to clarify that examination of the person includes the performance.

**Mrs Sullivan:** Just hang on here. I want to check what's in the original.

**Mr Jim Wilson:** Could I just ask for that explanation of the new wording from the parliamentary assistant again?

**Mr Wessinger:** Yes. Perhaps I should have legislative counsel, since it's their suggestion, give the reasons for the changes.

**Mr Doug Beecroft:** It depends on how the committee perceives this provision. If the committee thinks or wants to establish that diagnostic procedures are part of an examination, then the appropriate language would be to say "conduct an examination of the person, including diagnostic procedures." If the committee perceives that diagnostic procedures are something completely different from an examination, then there would be no change needed. I'm not sure what different members of the committee feel about that issue.

**Mr Jim Wilson:** Based on that explanation, I would certainly agree with the new wording, that diagnostic procedures are included in the examination. I think we'd want to actually ensure that is the case.

**Mrs Sullivan:** I would not be adverse to accepting an amendment, or just changing the words myself to "including diagnostic procedures." I think one of the things that should be clear is that, in every circumstance, the examination or the determination of the diagnosis may not include procedures which are intrusive, but in some circumstances they may. The thing they stick in your ear—I don't know what it's called—I think is seen to be an intrusive procedure in a controlled act. That will not necessarily be necessary in every diagnosis of a cold.

I don't want them to be mutually exclusive. I want them either together or apart but both of them there so that the physicians have the option of one or all or individually.



**Mr Wessenger:** If I might just ask, if the first change is made, "including the performance of," in the fifth line, should the word "or" be "and"?

**Mr Beecroft:** I think either the word "and" in the third line should be "or" or the word "or" in the fifth line should be "and" or the word "including" should be used. It depends on whether you perceive these things as different things or whether you perceive them as part of the same thing, whether the diagnostic procedures are done as part of an examination or whether they're a completely separate thing that's independent of an examination.

**Mr Jim Wilson:** All of us here who are speaking on this having gone through the RHPA, I would think there's agreement that in the RHPA hearings and legislation last summer we were well educated and well informed of examinations and diagnostic procedures. I would think there'd be no question among committee members now that they are part and parcel of an examination, if that examination is to be carried out thoroughly, and ensure that the health practitioner has the tools to do the job properly. Whatever wording is required to get that point across I would certainly be in favour of.

**Mrs Sullivan:** I think the phrase "including diagnostic procedures" is appropriate. I'm not certain whether the subsequent "or" is a significant change.

**Mr Beecroft:** Not a whole lot turns on the "or" in the fifth line if you put in the "including" because you would be saying that the diagnostic procedures are in effect part of the examination. I think "and" is a better word, because it does recognize that the diagnostic procedures are part of the examination; they're not separate from it.

2030

**Mr Jim Wilson:** And "and" is an equals.

**Mr Beecroft:** Yes.

**The Chair:** So what is the pleasure of the committee on the amendments?

**Mrs Sullivan:** Could I suggest that legislative counsel scribble on a sheet and then we can withdraw this one and get a clean, fresh, new amendment to come forward?

**Mr Beecroft:** Sure.

**The Chair:** You're agreeing to withdraw this motion?

**Mrs Sullivan:** Well, when I get the new one. It's staying there until I get the new one.

**The Chair:** Shall we stand this one down for now?

**Mr Wessenger:** Sure.

**Mrs Sullivan:** Stand it down for now.

**The Chair:** Agreed. Okay, PC motion 22(3.1).

**Mr Jim Wilson:** Mr Chairman, I'm prepared not to introduce this, given that it's extremely similar to what we've just debated.

**The Chair:** Thank you.

Government reprint 22(4). Agreed? Carried.

Government reprint 22(5) and 22(6). Agreed? Carried.

Government amendment 22(9).

Mr Wessenger moves that subsection 22(9) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Admission to hospital, etc

"(9) The authority to administer treatment under subsection (1), (2) or (3) includes authority to have the person admitted to a hospital or psychiatric facility for the purpose of the treatment, unless the person objects and the treatment is treatment of a mental disorder as defined in the Mental Health Act."

**Mr Wessenger:** The reason for this amendment is that where treatment is authorized under the emergency provisions, the unamended subsection 22(9) does not permit admission of a person for treatment of a mental disorder under the Mental Health Act, even if the person is not objecting. So just because a substitute is unavailable, the person could not be admitted. This change does not undermine the Mental Health Act's civil committal rules, because the emergency admission provisions would not give authority to keep the person in a psychiatric facility if the person subsequently objected. It's basically to cover the admission to a psychiatric facility where the person is not objecting; no reason why it shouldn't be permitted.

**Mr Jim Wilson:** Members will note that the next PC motion dealing with this is very similar, and I'm prepared to support the government's motion at this time and not introduce the PC motion. I note there was a provision similar to this, I believe, in the first draft of the legislation, or there was an intent there, and it's good to see that it's back, because we want to ensure that there are provisions for emergency admissions.

**Mrs Sullivan:** I'd like the government to clarify if the intent of the PC motion and the intent of the government motion are similar. I see that "unless the person objects here." You could have a person in a drug overdose situation, for example, objecting to admission to a hospital for treatment. The substitute decision-maker and the health practitioner would be at a loss in terms of delivering treatment to the person with the drug overdose because of the words "unless the person objects."

**Mr Wessenger:** I'm going to ask counsel to clarify that, because I would think this only refers to admission for a drug overdose, but not normally to a psychiatric facility. Am I right? I'll just ask.

**Mr Sharpe:** Subsection 22(9) dealing with authority—this is of course emergency treatment. Originally, there was no exemption. Concerns were raised again about circumventing the emergency provisions of the Mental Health Act and the question of whether there is such a thing as a true psychiatric emergency versus the physical emergency. It was felt that psychiatric emergencies on incapable or unconscious people should be dealt with through the Mental Health Act provisions, because those are emergency committal provisions.

The definition in the Mental Health Act of "mental disorder" has for many years been "disease or disability of the mind." In the example given, it's arguable that drunkenness or drug overdoses could create a temporary disability, but I believe most psychiatrists would argue that these are not true mental disorders in current usage justifying admission to a psychiatric facility. Not being an expert in that field, I really can't comment. From a legal perspective, it's

certainly arguable that disability of the mind could include temporary disability, however caused.

**Mrs Sullivan:** Thank you.

**Mr Jim Wilson:** That's a good point, though, that Mrs Sullivan has brought up. Maybe it's because the hour is getting late. Could I ask for that explanation again between the PC motion and the government motion? What is the effect, in layman's terms, of adding the additional sentence?

**Mr Wessinger:** You would like an explanation again from counsel with respect to this?

**Mr Jim Wilson:** Yes, just to be sure. Mrs Sullivan has raised a very good point.

**Mr Sharpe:** The rationale for the government motion is that the provision in the amended bill would preclude a non-objecting individual suffering from a psychiatric disorder from being admitted to a facility. If he or she objects, then there's the Mental Health Act committal power, even in an emergency. Now, of course, we're within the emergency provisions. But what if it's an emergency and the person isn't objecting to being taken into the facility? The way the bill is now worded in subsection 22(9), where it says, "other than treatment of a mental disorder as defined in the Mental Health Act," it would suggest that the person cannot be admitted, even if he or she is not objecting to gain assistance for the mental disorder which is quite critical and severe. Why would one need to commit them, if they're not objecting? Why deny them access to a facility—

**Mr Jim Wilson:** It's a voluntary measure.

**Mr Sharpe:** —just because they're suffering from a psychiatric disorder? You wouldn't if it was a physical disorder. If the person is objecting, then, as I indicated in an earlier comment, there are committal powers for that. But if he or she is not, then the person is arguably at a disadvantage because the emergency is psychiatric rather than physical.

**Mr Jim Wilson:** I appreciate the explanation and that's the way I understood it in the explanatory notes provided to me.

Motion agreed to.

**The Chair:** Any discussion on government reprint, section 23?

**Mrs Sullivan:** Mr Chairman, I'm now prepared with the assistance of legislative counsel to go back to subsection 22(3.1).

**The Chair:** Mrs Sullivan moves that subsection 22(3.1) of the bill, as reprinted to show the amendments proposed by the minister, be struck out and the following substituted:

"Examination

"(3.1) Despite sections 4 and 20, a health practitioner who is of the opinion that a person is incapable with respect to a treatment may conduct an examination of the person, including diagnostic procedures, without consent, if the examination and diagnostic procedures are reasonably necessary for the purpose of determining whether subsections (1), (2) or (3) apply to the treatment."

**Mrs Sullivan:** In putting that motion forward, I withdraw my previous motion which was similar.

**Mr Wessinger:** We're agreed.

Motion agreed to.

**Mrs Sullivan:** In that case the two motions I have with respect to altering the definition of "treatment" and the addition of "diagnostic evaluation" in subsection 1(1) are now withdrawn.

**The Chair:** Where are we now?

**Mrs Sullivan:** I had earlier stood down two amendments to subsection 1(1), one with respect to the definition of "treatment" and one with respect to the definition of "diagnostic evaluation." Since we've passed that amendment, those two are now stood down.

**The Chair:** You mean withdrawn?

**Mrs Sullivan:** Withdrawn.

**Mr Winner:** Are we calling it a day?

**Interjection:** We might be able to finish this off today.

**Mr Jim Wilson:** I don't want to spoil the party, but it may not be prudent to continue much further. It looks like what we have left can be handled fairly quickly in the morning and I for one am getting tired and starting to see clauses overlapping clauses. So in the public's best interest, it may be prudent that we start in the morning again fresh and get it cleaned up pretty quickly tomorrow.

**Mr Wessinger:** Perhaps we could just do one clause 20(a) motion and then we could perhaps consider adjourning.

**The Chair:** Sorry, which motion?

**Mr Wessinger:** It's a motion to strike out "seven days" and put in "forty-eight hours" in clause 20(a). I think we could do it very quickly.

**The Chair:** Is this a new motion?

**Mr Wessinger:** Yes, a new motion. It's one we forgot to do, so I'm told.

**Mrs Sullivan:** Do we have this one?

**Mr Winner:** Do we have it?

**The Chair:** No, we don't.

Mr Wessinger moves that clause 20(a) of the bill, as reprinted to show the amendments proposed by the minister, be amended by striking out "seven days" in the first line and substituting "forty-eight hours."

Motion agreed to.

**The Chair:** Mr Morrow.

**Mr Morrow:** Thank you very much, Mr Chair, for recognizing me. I really appreciate that. I want to help out the honourable member over there, Mr Wilson, and at this time, being so late in the evening and I'm sure we're all tired and we can get back to this in the morning, I will move adjournment.

**The Chair:** Mr Morrow has moved adjournment. All those in favour? Opposed? Carried.

This committee stands adjourned until 10 am tomorrow morning.

The committee adjourned at 2045.









## CONTENTS

Monday 14 September 1992

Consent to Treatment Act, 1992 . . . . . J-411

### STANDING COMMITTEE ON ADMINISTRATION OF JUSTICE

- \***Chair / Président:** Cooper, Mike (Kitchener-Wilmot ND)
- \***Vice-Chair / Vice-Président:** Morrow, Mark (Wentworth East/-Est ND)
- \*Akande, Zanana L. (St Andrew-St Patrick ND)
- \*Carter, Jenny (Peterborough ND)
- Chiarelli, Robert (Ottawa West/-Ouest L)
- \*Curling, Alvin (Scarborough North/-Nord L)
- Harnick, Charles (Willowdale PC)
- Mahoney, Steven W. (Mississauga West/-Ouest L)
- \*Malkowski, Gary (York East/-Est ND)
- Runciman, Robert W. (Leeds-Grenville PC)
- \*Wessenger, Paul (Simcoe Centre ND)
- \*Winninger, David (London South/-Sud ND)

#### **Substitutions / Membres remplaçants:**

- \*Miclash, Frank (Kenora L) for Mr Mahoney
- \*Sterling, Norman W. (Carleton PC) for Mr Harnick
- \*Sullivan, Barbara (Halton Centre L) for Mr Chiarelli
- \*Sutherland, Kimble (Oxford ND) for Ms Akande
- \*Wilson, Jim (Simcoe West/-Ouest PC) for Mr Runciman

\*In attendance / présents

#### **Also taking part / Autres participants et participantes:**

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Wessenger, Paul, parliamentary assistant to the Minister of Health

**Clerk / Greffière:** Freedman, Lisa

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